REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: _______________

Phone Number: ______________________________ Date: ______________________

Address: ____

1. Please describe what protected health information (PHI) that you want to change and include the reasons to support your request:

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2. If the Department decides to change the health information as requested, the Department will send the change to any person or organization that received the information before it was changed. Please provide the name(s) and address(es) if applicable.

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Please note that the Department cannot amend your PHI if:

- The information is accurate and complete
- You do not have the legal right to access the PHI you wish to have changed
- The Department did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it (if this is the case, please explain)
- The information you wish to change is not part of your Designated Record Set (medical record, billing record)

The Department may accept or deny your request to amend as permitted under law. If denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within 60 days of receipt of this request. The Department may extend the response period for up to an additional 30 days by notifying you in writing.

____
Patient or Legal Representative

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Date

____
Date Received by Department