

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient's Name:	_____		
	Last	First	Middle
Home Address:	_____		

Home Phone:	_____	Date of Birth:	_____

I hereby request that Kewaunee County amend **[please check all boxes that apply]**:

- My medical records.
- My billing records.
- My enrollment, payment, claims adjudication, case or medical management records
- My records used by or for Kewaunee County to make decisions about me.

I understand that Kewaunee County may deny this request as permitted under federal law. I further understand that if Kewaunee County denies my request, I will be informed in writing by Kewaunee County of its reason for the denial and what I should do if I disagree with the denial. I further understand that Kewaunee County will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If Kewaunee County is unable to comply with my request within this timeframe, I understand that it may extend the applicable deadline for up to an additional thirty (30) days) by notifying me in writing.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results)

2. Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services) _____

3. What is your reason for making this request? _____

4. How is the entry incorrect, incomplete, or outdated? _____

5. What should the entry say to be more accurate or complete? (Please be as specific as possible) _____

6. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)?

___ yes ___ no

If yes, please specify the name(s) and address(es) of the organizations or individuals(s).

Signature of Patient or Patient's Personal Representative _____

Date _____

FOR [ORGANIZATION] USE ONLY

Amendment has been: ___ Accepted___ Denied

If denied, check the reason for denial:

- ___ Protected Health Information was not created by this Kewaunee County
- ___ Protected Health Information is not part of the patient’s Designated Record Set
- ___ Protected Health Information is not accessible by the patient under Kewaunee County’s policy regarding the patient’s right to access his or her Protected Health Information
- ___ Protected Health Information is accurate and complete

Comments _____

Signature of Department Privacy Officer _____ Date _____