

**KEWAUNEE COUNTY
ACCEPTANCE OF REQUEST FOR
AMENDMENT OF PROTECTED HEALTH INFORMATION**

Patient's Name:			
	Last	First	Middle
Home Address:			
Home Phone:		Date of Birth:	
Date of Amendment Request Form:		Date of this Acceptance Form:	

Your request to amend your protected health information maintained by Kewaunee County) relating to: **[check the appropriate box]**

- your medical records;
- your billing records, payment, claims adjudication, case or medical management records;
- your enrollment, payment, claims adjudication, case or medical management records; or
- records maintained by or for Kewaunee County to make decisions about you

has been accepted. Please identify on the following line the individual/persons/organization with whom you would like us to share the amendment and sign this form below to indicate your agreement for Kewaunee County to share the amendment with the individual/persons/organization so identified. _____

Signature of Patient or
Patient's Personal Representative

Date

Printed name of the person signing and
(if not the patient) the relationship to the
patient