REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Name: _____ Date of Birth: _____

Please tell us what protected health information you want changed:

_____

_____

Please tell us why you want this change. You must give a reason:

_____

_____

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide. Please tell us how to contact you:

Name: _____

Address: _____

City _____, State _____ Zip Code _____

Phone Number: _____

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information:

❑ No. Initials: _____

❑ Yes. Please list the persons' names and addresses:

Name:	Name:
Address:	Address:
City:	City:
State:	State:
Zip Code:	Zip Code:

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

❑ No. Initials: _____

❑ Yes. Initials:_____

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

2. The information is accurate and complete.

3. You do not have the legal right to access the protected health information you want changed.

4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

For more information about your privacy rights, see the Notice of Privacy Practices" available at the front desk of our health center or send a written request to 1000 Vale Terrace, Vista, CA 92084

If you believe your privacy rights have been violated, you may file a complaint with the health center or with the Secretary of the Department of Health and Human Services. To file a complaint with the health center, contact Privacy Officer, 1000 Vale Terrace, Vista, CA 92084, (760) 631-5000 ext. 1133. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

When you have finished filling out this form, please send it to 1000 Vale Terrace, Vista, CA 92084, or bring it to the health center.

Signature of patient or representative: _____

If representative, give relationship: _____

Identification is required to insure that the requestor has the authority to request this amendment

Type of ID Submitted	Person verifying identity	Date