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Request to Amend Protected Health Information

Under Public Law 104-191, also known as HIPAA, you are entitled to request an amendment of your personal medical records upon written request.

Patient Information	Patient Legal Name: _____ Date of Birth: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
Information	Name of author(s) of inaccurate or incomplete note(s): _____ Date(s) of service to be amended: _____ _____ _____
Explanation	Please explain how to the documentation is inaccurate or incomplete: _____ _____ _____ _____ _____ _____
Amendment Requested	Please state exactly what you think the entry should state to be accurate and complete: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Rights and Acknowledgements	<p>Policies and Limitations on Amendments to Personal Medical Records</p> <ul style="list-style-type: none"> • Under federal law, we may accept your request for amendment(s) to your medical records, or we may deny your request. If we deny your request, we must include a copy of your disagreement in your medical records, along with your request. • We are only required to amend information that is in your “Designated Record Set,” which is medical, personal, and business office information that we created and maintain in our facility, and which is used to directly make decisions about your healthcare and treatment. If the information you wish to have amended was created by another entity, you should contact that entity directly to have that information amended. • The following kinds of information are exempted from amendment: <ul style="list-style-type: none"> ○ Items not maintained in legal health records ○ Education records exempt from HIPAA ○ Psychotherapy Notes ○ Data exempted by the Clinical Lab Improvements Act ○ Data involved in criminal, civil, or administrative actions ○ Records put together in anticipation of legislation • Under federal law, we must act on your request for amendment(s) within sixty (60) days of your initial request, by either amending your medical records or by providing you with a written denial of your request. We may take an additional thirty (30) days to act on your request, but only if we provide you with a written notice of the reason for the delay and an expected completion date. • If we deny your request for amendment, we will provide you with a written notice of the reason(s) for the denial. <ul style="list-style-type: none"> ○ You have the right to file a “Statement of Disagreement” with the denial. ○ You have the right to file a complaint with the US Department of Health and Human Services over the denial of amendment
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Signature	<p>Signature: _____ Date: _____</p> <p style="text-align: center;"><small>(Patient, Power of Attorney, or Legal Representative)</small></p> <p>Representative Relationship: _____</p> <p><small>NOTE: If legal representative in any capacity, please attach documents if not already filed with DAP Health.</small></p>
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Staff Use Only	<p>Employee Name: _____</p> <p>I have witnessed the execution of this request.</p> <p>Employee Signature: _____ Date: _____</p>
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