COOS HEALTH AND WELLNESS
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Client's Name: _____
Last First Middle

Home Address: _____

_____

Home Phone: _____ **Date of Birth:** _____

I hereby request that Coos Health and Wellness 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 Coos Health and Wellness to make decisions about me.

(All as more specifically described below.)

I understand that CHW may deny this request as permitted under federal law. I further understand that if CHW denies my request, I will be informed in writing by CHW of its reason for the denial and what I should do if I disagree with the denial. I further understand that the CHW will notify me of its decision to accept or deny my request within sixty (60) days of receiving this request. If CHW is unable to comply with my request within this time frame, 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) _____

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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 How is the entry incorrect, incomplete, or outdated?_____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 client or client's Personal Representative _____

Date _____

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FOR CHW USE ONLY

Amendment has been: ___ Accepted___ Denied

If denied, check the reason for denial:

____ Protected Health Information was not created by this CHW.

____ Protected Health Information is not part of the client's Designated Record Set.

____ Protected Health Information is not accessible by the client under the Department's policy regarding the client's right to access his or her Protected Health Information.

____ Protected Health Information is accurate and complete.

Comments _____

_____

_____

_____

_____

Signature of Privacy Officer _____Date _____