



Request to Amend Protected Health Information

I understand that I have the right to request an amendment to incorrect or incomplete protected health information subject to some limitations. I understand CMU shall respond to my request for amendment in fewer than 60 days from the date of my request. CMU may deny my request to amend my protected health information, but I have the right to a statement of CMU's disagreement placed in my records.

Client/Patient/Employee Name: _____ Date: _____

(Please Print Clearly.)

Address: _____ Telephone: _____

Identify the specific item(s) in the record that you would like to be changed (amended).

(Use additional pages if necessary.)

Client/Patient/Employee Signature

Date

Guardian Signature, if appropriate

Relationship to Client

Attachment E

(For office use only)

___ Request Denied

___ Approved as Requested

___ Approved Per Comments

Comments: _____

Privacy Officer Signature: _____

Review Date: _____

PO Job Title: _____

Client Informed in Writing: Yes ___

Contact Date: _____