



REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL DIVISION

SFN 1981 (6-2023)

CLIENT INFORMATION

Client Name (Last, First, Middle Initial)		Date of Birth	
Previous Names Used			
Address	City	State	ZIP Code
Name of the Department Health Plan, Health Care Facility, or Program Providing Health Care			
Telephone Number (if we have questions regarding your request)			

You (or your legal representative) have the right to request amendments to your protected health information (PHI) maintained by a Department of Health and Human Services (Department) health plan, health facility, or program providing health care. A separate request must be made to each Department health plan, health care facility, or program providing health care. The Department will act upon your request within 60 days of the receipt of your request. The Department may extend the deadline for up to 30 additional days by notifying you in writing. If the Department agrees with the amendment you requested, you will be notified in writing and the PHI will be amended per Department policy. If the Department denies your request, you will be notified in writing of the denial and the reasons for the denial. You have the right to disagree with the Department's denial. You may state why you disagree in a written Statement of Disagreement that will be added to your designated record set. If the Department continues to disagree with your requested amendment, it may place a Rebuttal Statement in your designated record set on why it does not agree with your Statement of Disagreement. A copy of the Rebuttal Statement will be provided to you.

If you are requesting the Department amend your PHI, please consider the following:

- The Department will only amend PHI that is part of your designated record set.
- The Department cannot amend PHI that it did not create unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
- If your PHI is amended, the Department may need to obtain your permission to share the amendment with others who received the PHI prior to the amendment.
- If your PHI is amended, the original PHI will be retained in your designated record set.
- Pursuant to federal and state law, the Department may disclose the original PHI, amended PHI, your request for amendment, its denial, your Statement of Disagreement, and its Rebuttal Statement.
- If the Department denies your request and you do not file a Statement of Disagreement, you must request in writing that your request for amendment and the Department's denial be included with any future disclosures of the PHI.
- You will need to provide the Department with any information you have to support your request.

Identify or describe the PHI you want amended. Include the dates of the PHI.
--

Explain the reason you believe the PHI is inaccurate or incomplete and how you would like it changed.

If your request is accepted, provide a list of individuals or organizations who have received copies of the PHI that you would like notified of the amendment.

Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

FOR DEPARTMENT USE ONLY

Date Request was Received	Date Decision was Made	Date Written Notice Sent to Client
<input type="checkbox"/> Request Approved <input type="checkbox"/> Request Denied <input type="checkbox"/> Request Approved and Denied in Part <i>(A copy of the written notice provided to the individual approving or denying the request must be attached to this form.)</i>		
Comments		
Printed Name of Department Representative	Signature	Date

Statement of Disagreement *(A copy of the Statement of Disagreement or request to include amendment and denial with future disclosures must be attached to this form.)*

Statement of Disagreement received: _____ (mm/dd/yyyy)

Written request to include amendment request and denial with future disclosures received: _____ (mm/dd/yyyy)

Comments

Printed Name of Department Representative	Signature	Date
---	-----------	------

Department Rebuttal to Statement of Disagreement *(A copy of the Rebuttal Statement must be attached to this form.)*

Written Rebuttal Statement to Statement of Disagreement provided to client: _____ (mm/dd/yyyy)

Comments

Printed Name of Department Representative	Signature	Date
---	-----------	------