Behavioral Health Department Alameda County Health	By: Signed by: BA167CA0C0D444A... **Karyn L. Tribble, PsyD, LCSW, Director**
POLICY TITLE **Client Right to Request Amendment of Health Records**	**Policy No: 300-3-1** **Date of Original Approval**: 12/16/2019 **Date(s) of Revision(s):** 8/25/2025

PURPOSE

This policy establishes the requirements for processing and responding to a client's request to amend records held by Alameda County Behavioral Health Department (ACBHD) and/or its contracted providers under the Health Insurance Portability and Accountability Act (HIPAA) and related Federal and State regulations.

AUTHORITY

- 45 C.F.R. §§ 164.502, 164.526
- CA Health & Safety Code §§ 123111, 123115, 123116

SCOPE

All ACBHD County-Operated programs and all ACBHD-contracted and subcontracted mental health and substance use disorder (SUD) service providers, including both individuals and entities, are required to adhere to this policy.

BACKGROUND

Required State and Federal regulations govern a client's right to request amendments to their health records.

POLICY

Clients receiving services from ACBHD or its contracted providers or designated personal representatives have the right to request an amendment to their health records. Requests for an amendment of records will be processed in accordance with HIPAA and State regulations.

Clients or designated personal representatives also have the right to provide a written addendum with respect to any item or statement in their records they believe to be incomplete or incorrect. Requests for an addendum to records will be processed in accordance with the California Health and Safety Code.

ACBHD or its contracted providers may deny an individual's request for amendment, if they determine that the protected health information (PHI) or record that is the subject of the request:

I. Was not created by ACBHD or the contracted provider, unless the client provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
II. Was not part of the designated record set.
III. Would not be available for inspection because it consists of:
    A. Psychotherapy notes.
    B. Information compiled in reasonable anticipation of, or for use in a legal or administrative action or proceeding.
    C. PHI maintained by a correctional institution or a health care provider acting under direction of a correctional institution, where an inmate obtaining the requested PHI would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other inmates or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate.
    D. PHI created or obtained by a provider in the course of research that includes treatment, as long as the research is in progress if the client agreed to the denial of access when consenting to participate in the research treatment, and the provider has informed the client that access would be reinstated upon completion of research.
    E. PHI subject to the Privacy Act (5 U.S.C. 552a), if the denial meets that law's requirements.
    F. PHI obtained from someone other than a health care provider under a promise of confidentiality, where access requested would be reasonably likely to reveal the source of the information.
    G. PHI that a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person*.
    H. PHI that references another person (that is not a health care provider), which a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person*.
    I. PHI requested by a client's personal representative, where a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person*.

**Note that if denial is for categories G – I, a client has the right to have the denial reviewed by a licensed health care professional who is designated by ACBHD or its contracted provider to act as a reviewing official and who did not participate in the original decision to deny. ACBHD or its contracted provider must provide or deny access in accordance with the determination of this reviewing official.*

IV. If the author of the note believes that the note is accurate and complete.

Parties Responsible for Processing Amendment and Addenda Requests

I. For requests for amendment and addenda of records maintained by ACBHD, the Custodian of Records or their designee shall be responsible for:
    A. Assisting clients with drafting these requests, as needed.
    B. Accepting client requests for amendments and addenda.
    C. Working with the appropriate county clinical staff to review and respond to the request.
II. For requests for amendment of records maintained by ACBHD's contracted providers, a designated staff person at the provider's office shall be responsible for:
    A. Assisting clients with drafting these requests, as needed.
    B. Accepting client requests for amendments and addenda.
    C. Working with the appropriate clinical staff to review and respond to the request.

Information regarding requests for amendments and addenda, including completed forms for requests for amendments and addenda, and correspondence relating to acceptance or denial of these requests shall be filed in the client's designated record set and appended to the relevant records.

Requests for Unemancipated Minors:

Parents or legal guardians have the right to request amendment of the medical records of an unemancipated minor if they are the minor's personal representative.

However, parents or legal guardians do not have this right if they are not the minor's personal representative, which includes the following situations:

- The minor is the one who consents to care, and the consent of the parent is not required under law.
- The minor obtains care at the direction of a court, or a person appointed by the court.
- When, and to the extent that, the parent agrees that the minor and health care provider may have a confidential relationship.

A provider may not share the medical records of a minor if they determine that access to the client records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor client or the minor's physical safety or psychological well-being.

A provider may also choose not to treat a parent or legal guardian as a personal representative when the provider reasonably believes, in their professional judgment, that the child has been or may be subjected to domestic violence, abuse or neglect.

A psychotherapist who knows that a minor has been removed from the physical custody of their parent or guardian may not allow a parent or legal guardian access to the mental health records of a minor client, except where a juvenile court issues an order authorizing the parent or guardian access to the mental health records of the minor client after finding that such an order would not be detrimental to the minor client.

PROCEDURE

I. Making a Request for Amendment

A. Clients that wish to make a request for amendment to their health records will contact the ACBHD Custodian of Records for information maintained by ACBHD, or a designated staff person at the provider's office for information maintained by their contracted provider, to submit a Request for Amendment or Request for Addendum form (Appendix A).

If a client needs assistance to complete the request form, the ACBHD Custodian of Records or designated staff for the contracted provider may complete the form on the client's behalf or accept an informal written request for amendment or addendum if the request provides sufficient information to process the request.

B. The Custodian of Records or contracted provider's designated representative will forward the request to the appropriate clinical staff for review and evaluation of the request.

II. Timeline of Response to Request for Amendment

A. ACBHD or the contracted provider must act on the request for amendment no later than 60 days after receipt of the request.

B. One Time Extension: If ACBHD or the contracted provider is unable to act on the request for amendment within 60 calendar days of the receipt of the written request, there may be a one-time extension of 30 calendar days. ACBHD or the contracted provider must notify the client in writing, including reasons for the delay and the date by which the request will be processed.

III. Acceptance of Request for Amendment

If ACBHD or the contracted provider accepts the amendment in part or whole, ACBHD or the contracted provider will take the following steps:

A. The treating clinician or author of note, or the designated staff of the contracted provider, shall identify the records in the designated record set affected by the amendment and make the appropriate amendments. The treating clinician or a representative will ensure that the amended documents are placed appropriately in the client's designated record set, working with Information Services for those documents created, maintained, or stored electronically in Clinicians Gateway, Imavisor, and Laserfiche. The records will be stored and maintained by ACBHD Record & Retention Policy.

B. The treating clinician or author of note, or the designated staff of the contracted provider, shall notify the client in writing within 60 calendar days of receipt of the written request for amendment that the amendment is accepted.

C. The treating clinician or author of note, or the designated staff of the contracted provider, must obtain the client's identification of, and agreement to have the provider notify the relevant persons with which the amendment needs to be shared. The treating clinician or author of note, or the designated staff of the contracted provider, must make reasonable efforts to inform and provide the amendment within a reasonable time to:
    1. Persons identified by the client as having received the PHI about the client and needing the amendment and
    2. Persons, including business associates, that the provider knows have the PHI that is the subject of the amendment, and that may have relied or could foreseeably rely on such information to the detriment of the client.

IV. Denial of Request for Amendment

If ACBHD or the contracted provider determines that the request for amendment should be denied in part or whole, the treating clinician or author of note or the designated staff of the contracted provider will take the following steps:

A. The treating clinician or author of note, or the designated staff of the contracted provider must notify the client in writing within 60 calendar days of the written request.

B. The denial must use plain language and contain all of the following:
    1. The basis for the denial.
    2. A statement that the client has a right to submit a written statement disagreeing with the denial and an explanation of how the client may file such a statement.

3. A statement that if the client does not submit a statement of disagreement, the client may request that the provider provide the client's request for amendment and the denial with any future disclosures of the PHI that is subject of the amendment.
4. A description of how the client may file a complaint with ACBHD or the contracted provider or to with Secretary of the U.S. Department of Health and Human Services (under 45 CFR 160.306). This description shall include the name, title, and phone number of the contact person to receive the complaint, which in the case of ACBHD is:

   By phone: 1-800-779-0787 Consumer Assistance For assistance with hearing or speaking, call 711, California Relay Service
   Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

   In Person: By visiting Consumer Assistance at Mental Health Association, 2855 Telegraph Ave, Suite 501, Berkeley, CA 94705

   With your provider: Your provider may resolve your grievance internally or direct you to the Consumer Grievance and Appeal Process webpage. You may obtain forms and assistance from your provider.

C. **Statement of Disagreement:** ACBHD or the contracted provider must permit the individual to submit a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The written statement of disagreement shall be limited to 250 words per alleged incomplete or incorrect item in the client's record.

D. **Rebuttal Statement:** ACBHD or the contracted provider may prepare a written rebuttal to the client's statement of disagreement. Whenever such a rebuttal is prepared, the treating clinician or author of note, or the designated staff of a contracted provider must provide a copy to the client who submitted the statement of disagreement.

E. **Recordkeeping:** ACBHD or the contracted provider must identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the following documentation to the designated records set:
   1. The client's Request for Amendment form
   2. ACBHD or the contracted provider's denial letter
   3. The client's statement of disagreement, if any

4. ACBHD or the contracted provider's written rebuttal, if any

F. **Future Disclosures of PHI that is the Subject of the Disputed Amendment:**
   1. If the client submitted a statement of disagreement, ACBHD or the contracted provider must include the recordkeeping information above or an accurate summary of such information with all future disclosures of the PHI to which the disagreement relates.
   2. If the client did not submit a statement of disagreement but has requested that ACBHD or the contracted provider provide the Request for Amendment and the denial letter with any future disclosures of the PHI related to the disagreement, ACBHD or the contracted provider must include these documents or an accurate summary with any subsequent disclosure of the relevant PHI.

V. Request for Addendum to Client Records

A. Clients have the right to provide ACBHD or a contracted provider with a written addendum with respect to any item or statement in their records that they believe to be incomplete or incorrect. Clients shall submit a request for a written addendum to the treating clinician or author of note, or the designated staff of the contracted provider.

B. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the client's record and shall clearly indicate in writing that the client requests the addendum to be made a part of their record.

C. The treating clinician or author of note, or the designated staff of the contracted provider, shall attach the addendum to the client's records and shall include that addendum in future disclosures of the allegedly incomplete or incorrect portion of the client's records to any third party.

D. The receipt of information in a client's addendum which contains defamatory or otherwise unlawful language, and the inclusion of this information in the client's records, shall not subject ACBHD or the contracted provider to liability in any civil, criminal, administrative, or other proceedings.

VI. Actions on Notices of Amendment from Other Health Care Providers

If another health care provider or mental health plan notifies ACBHD or its contracted provider of an amendment to PHI in a client's designated record set, the treating clinician or

author of note, or the designated staff of the contracted provider shall make the amendment in ACBHD's or the contracted provider's records for the client.

NON-COMPLIANCE

I. Non-Compliance Definition

Non-compliance with this policy is defined as any deviation from the policies or procedures described above.

II. Procedures in the Event of Non-Compliance

In the case of non-compliance, a client or personal representative may file a grievance with ACBHD or the contracted provider or to the Secretary of the U.S. Department of Health and Human Services.

For ACBHD, the contact information for complaints may be sent:

By phone: 1-800-779-0787 Consumer Assistance For assistance with hearing or speaking, call 711, California Relay Service

Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606

In Person: By visiting Consumer Assistance at Mental Health Association, 2855 Telegraph Ave, Suite 501, Berkeley, CA 94705

With your provider: Your provider may resolve your grievance internally or direct you to the Consumer Grievance and Appeal Process webpage. You may obtain forms and assistance from your provider.

Any communication that contains PHI or otherwise confidential information should be sent through secure methods such as fax, mail, or using email with secure encryption.

The client or staff should try to submit the complaint within 180 days of the event of non-compliance, but complaints will be accepted after that period.

Clients and staff who submit a complaint about non-compliance will not face retribution for filing a complaint.

CONTACT

ACBHD Office	Current As Of	Email
Anthony Austin, Custodian of Records, Quality Assurance	6/30/2025	Anthony.Austin@acgov.org
Adrienne Carlisle, Compliance and Privacy Officer, AC Health Office of Compliance Services	6/30/2025	Adrienne.Carlisle@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBHD Staff
- ACBHD Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Anthony Austin, RHIT, Custodian of Records; Sophia Lai, Interim Privacy Author
Original Date of Approval: 12/16/2019 by Dr. Karyn L. Tribble, Behavioral Health Director

Revision Author	Reason for Revision	Date of Approval by (Name, Title)
Anthony Austin, RHIT, Custodian of Records, Quality Assurance,	Annual review and update of policy to reflect current processes.	8/25/2025 by Dr. Karyn L. Tribble, Behavioral Health Director

DEFINITIONS

Term	Definition
Designated Record Set	A group of records maintained by or for a health care provider that is: (i) The medical records and billing records about clients maintained by or for a health care provider; (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) Used, in whole or in part, by or for the covered entity to make decisions about clients.

	The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a health care provider.
Protected Health Information (PHI)	Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. PHI excludes the following individually identifiable health information: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g, including records described at 20 U.S.C. 1232g(a)(4)(B)(iv); (ii) Employment records held by a provider in its role as employer; and (iii) Records regarding a person who has been deceased for more than 50 years.

APPENDICES

- Appendix A: Request for Amendment or Addendum Forms

FORM 15-4

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Patient name: _____

Date of birth: _____ Medical Record #: _____

Please tell us what protected health information you want changed:

_____

_____

_____

_____

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

_____

_____

_____

_____

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

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.

Tell us where to send you a letter:

_____

_____

Give a phone number so we can call you: _____

(over)

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. Tell us if there are any such persons who need the changed information:

☐ No Initials: _____ ☐ Yes Initials: _____

Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

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.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at [insert web address] or at [department name] at [insert hospital name] or by sending a written request to [insert address].

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. 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 [insert address] or bring it to the [insert department name] at [insert hospital name].

SOLICITUD DE ENMIENDA DE INFORMACIÓN MÉDICA PROTEGIDA

Fecha: _____

Nombre del paciente: _____

Fecha de nacimiento: _____ Número de historia clínica: _____

Por favor indique la informaci6n medica protegida que desea modificar:

_____

_____

_____

_____

Indique el motivo por el cual desea hacer esta modificaci6n. Debe indicar un motivo:

_____

_____

_____

_____

TENGA EN CUENTA: No podemos borrar ni destruir ninguna información ya incluida en su historial medico. S6lo podemos agregar comentarios que aclaren o corrijan.

Debemos informarle durante los pr6ximos 60 dias si modificaremos su informaci6n medica protegida según lo ha solicitado, o le indicaremos que necesitamos más tiempo (hasta 30 días adicionales) para tomar una decisión.

Indique el domicilio donde podemos enviarle una carta:

_____

_____

Proporcione un numero de telefono a fin de que podamos llamarle: _____

(sobre)

Si tomamos la decisi6n de modificar la informaci6n medica segun lo ha solicitado, le enviaremos la modificaci6n a todas las personas que hayan recibido la informaci6n antes de que fuera modificada. Indique si existen personas que deben recibir la informaci6n modificada:

☐ No Iniciales: _____ ☐ Sí Iniciales: _____

Escriba los nombres y domicilios de estas personas:

_____ _____

_____ _____

_____ _____

Asimismo, enviaremos la enmienda a otras personas que sabemos que han recibido la información antes de que fuera modificada si se basaron, o es posible que en un futuro se basen, en la informaci6n en su perjuicio (daño). ¿Está de acuerdo con esto?

☐ No Iniciales: _____ ☐ Sí Iniciales: _____

No es necesario que modifiquemos su informaci6n medica protegida si:

1. Nosotros no creamos la informaci6n, a menos que la persona que haya creado la informaci6n no este disponible para responder a su solicitud de cambio (por ejemplo, si el medico que cre6 la informaci6n originalmente ha fallecido). Si esta excepción corresponde en su caso, explique:

   _____

   _____

2. La información es correcta y está completa.
3. Legalmente usted no tiene acceso a la informaci6n medica protegida que desea modificar.
4. La informaci6n medica protegida que usted desea modificar no forma parte del conjunto de expedientes designados. Estos incluyen sus expedientes medicos, los registros de facturaci6n y los expedientes que contienen la informaci6n medica protegida que nosotros utilizamos para tomar decisiones acerca de usted.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relaci6n con este: _____

Nombre en letra de imprenta: _____
(representante legal)

Para obtener mas informaci6n acerca de sus derechos de confidencialidad, lea "Notice of Privacy Practices" disponible en nuestra sede en la red en [insert web address] o en el [insert department name] del [insert hospital name] o puede enviarnos una solicitud por escrito a [insert address].

Si usted considera que se han transgredido sus derechos de confidencialidad, puede presentar una queja en el hospital o ante el Secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para presentar una queja en el hospital, debe comunicarse con [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. Todas las quejas deben presentarse por escrito.

No se le aplicarán sanciones por presentar una queja.

Cuando haya terminado de completar el formulario, puede enviarlo a [insert address] o llevarlo al [insert department name] del [insert hospital name].

RESPONSE TO REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Address: _____

_____

Dear: _____
(name of recipient)

We received your request to change your protected health information.

- ☐ We need more time to process your request. We will send you a response to your request by *(date)* _____.
- ☐ We will make the change as you requested and will notify the persons you designated of the change.
- ☐ We will make the change that you requested, but only in part, and will notify the persons you designated of the change.

The part of the change that we will make is:

_____

_____

_____

The part of the change that we will not make is:

_____

_____

_____

- ☐ We will not make the change as you requested because:
  - ☐ You did not include a reason to support your request.
  - ☐ The information we have is accurate and complete.
  - ☐ We did not create the information you want changed, and you did not give us a reasonable basis to believe that the originator of the information is no longer available to act on your request to change the information.
  - ☐ The information you want changed is not information that you have a right to access.

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

If we denied your request to change your protected health information, in whole or in part, you may submit a "Statement of Disagreement." If you do not submit a "Statement of Disagreement" you may ask us to include your amendment (change) request and our denial along with all future disclosures of the information that you wanted changed.

If you want to submit a "Statement of Disagreement," please write "Statement of Disagreement" on the top and send it to [insert address] or bring it to the [insert department name] at [insert hospital name].

If you want us to include your amendment (change) request and our denial along with future disclosures of the information that you wanted changed, please send a letter to [insert address] or bring it to the [insert department name] at [insert hospital name].

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at [insert web address] or at [insert department name] at [insert hospital name] or by sending a written request to [insert address].

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. All complaints must be submitted in writing.

You will not be penalized for ftling a complaint.

Sincerely,

Hospital representative

REPUESTA A LA SOLICITUD DE ENMIENDA DE INFORMACIÓN MÉDICA PROTEGIDA

Date: _____

Address: _____

_____

Estimados: _____
(name of recipient)

Hemos recibido su solicitud para cambiar su informaci6n medica protegida.

- ☐ Necesitamos más tiempo para procesar su solicitud. Le enviaremos una respuesta a su solicitud antes del _____.
- ☐ Haremos el cambio según lo ha solicitado y le informaremos a las personas que ha designado acerca de dicho cambio.
- ☐ Haremos el cambio que ha solicitado pero sólo parcialmente, y le informaremos a las personas que ha designado acerca de dicho cambio.

La parte del cambio que haremos es:

_____

_____

_____

La parte del cambio que no haremos es:

_____

_____

_____

- ☐ No haremos el cambio que ha solicitado debido a que:
  - ☐ Usted no incluyó un motivo que respalde su solicitud.
  - ☐ La información que tenemos es correcta y está completa.
  - ☐ Nosotros no creamos la información que usted desea cambiar, y usted no nos proporcionó un motivo razonable para creer que el creador original de la información ya no está disponible para responder a su solicitud de cambiar la información.
  - ☐ La información que desea cambiar no es información a la que usted tenga acceso legalmente.

- ☐ La información que usted desea cambiar no forma parte del conjunto de expedientes designados. Esto significa sus expedientes medicos, los registros de facturaci6n y los expedientes que contienen la informaci6n medica protegida que nosotros utilizamos para tomar decisiones acerca de usted.
- ☐ Otras consideraciones _____

Si negamos su solicitud de enmienda de su informaci6n medica protegida, en parte o en su totalidad, usted puede presentar una “Manifestación de Desacuerdo”. Si usted no presenta una “Manifestación de Desacuerdo”, puede solicitarnos que incluyamos su solicitud de enmienda (cambio) y nuestra negativa en todas las divulgaciones futuras de la información que usted desea cambiar.

Si desea presentar una “Manifestación de Desacuerdo”, escriba “Manifestación de Desacuerdo” en la parte superior y enviela a [insert address] o llevela al [insert department name] del [insert hospital name].

Si desea que incluyamos su solicitud de enmienda (cambio) y nuestra negativa en las divulgaciones futuras de la informaci6n que deseaba cambiar, envie una carta a [insert address] o llevela al [insert department name] del [insert hospital name].

Para obtener mas informaci6n acerca de sus derechos de confidencialidad, lea "Notice of Privacy Practices" disponible en nuestra sede en la red en [insert web address] o en el [insert department name] del [insert hospital name] o puede enviarnos una solicitud por escrito a [insert address].

Si usted considera que se han transgredido sus derechos de confidencialidad, puede presentar una queja en el hospital o ante el Secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para presentar una queja en el hospital, debe comunicarse con [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. Todas las quejas deben presentarse por escrito.

No se le aplicarán sanciones por presentar una queja.

Muy atentamente,

Representante del Hospital

NOTIFICATION OF AMENDMENT TO PROTECTED HEALTH INFORMATION

Date: _____

Address: _____

_____

Dear: _____
(name of recipient)

Patient name: _____

Date of birth: _____

The patient named above requested an amendment to his or her protected health information (PHI). We granted this request, in whole or in part, as follows:

_____

_____

_____

_____

You must amend the PHI in designated record sets by appending or otherwise providing a link from the PHI to the location of the amendment.

If you have any questions, please call [insert name and phone number of contact person].

Sincerely,

Hospital representative

STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE AMENDMENT REQUEST AND DENIAL WITH FUTURE DISCLOSURES

Date: _____

Patient name: _____

Date of birth: _____ Medical Record #: _____

Address: _____

_____

Phone Number: _____

I understand that *(name of hospital)* _____ _____ denied my request to change my protected health information. My request was dated _____.

Mark only one box below:

☐ I want to file this "Statement of Disagreement." I disagree with the denial because:

_____

_____

_____

_____

I understand that the hospital may prepare a written rebuttal to my Statement of Disagreement. A **"rebuttal"** is a statement of why the hospital thinks my Statement of Disagreement is wrong. If the hospital prepares a written rebuttal, I will receive a copy.

☐ I do not want to file a "Statement of Disagreement," but I want *(name of hospital)* _____ _____ to include my amendment (change) request and the denial along with all future disclosures of the information subject to my amendment request.

(over)

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at [insert web address] or at [insert department name] at [insert hospital name] or by sending a written request to [insert address].

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. All complaints must be submitted in writing.

You will not be penalized for ftling a complaint.

MANIFESTACIÓN DE DESACUERDO/SOLICITUD DE INCLUIR LA SOLICITUD DE ENMIENDA Y LA NEGATIVA EN DIVULGACIONES FUTURAS

Fecha: _____

Nombre del paciente: _____

Fecha de nacimiento: _____ Número de historia clínica: _____

Domicilio: _____

_____

Numero de telefono: _____

Entiendo que el *(nombre del hospital)* _____ _____ ha negado mi solicitud de cambiar mi información medica protegida. La fecha de mi solicitud fue _____.

Marque sólo un casillero a continuación:

☐ Deseo presentar esta "Manifestación de Desacuerdo." Estoy en desacuerdo con la negativa debido a que:

_____

_____

_____

_____

Entiendo que el hospital puede preparar una refutación a mi Manifestación de Desacuerdo por escrito. Una **"refutación"** es una manifestación de los motivos por los cuales el hospital considera que mi Manifestación de Desacuerdo es err6nea. Si el hospital prepara una refutaci6n por escrito, recibire una copia.

☐ No deseo presentar una "Manifestación de Desacuerdo," pero deseo que el *(nombre del hospital)* _____ incluya mi solicitud de enmienda (cambio) y la negativa en todas las divulgaciones futures de la información sujeta a mi solicitud de enmienda.

(sobre)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relaci6n con este: _____

Nombre en letra de imprenta: _____
(representante legal)

Para obtener mas informaci6n acerca de sus derechos de confidencialidad, lea "Notice of Privacy Practices" disponible en nuestra sede en la red en [insert web address] o en el [insert department name] del [insert hospital name] o puede enviarnos una solicitud por escrito a [insert address].

Si usted considera que se han transgredido sus derechos de confidencialidad, puede presentar una queja en el hospital o ante el Secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para presentar una queja en el hospital, debe comunicarse con [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. Todas las quejas deben presentarse por escrito.

No se le aplicarán sanciones por presentar una queja.