

**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: \_\_\_\_\_\_\_\_\_\_\_\_

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

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*(Use additional pages if necessary.)*

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Client/Patient/Employee Signature Date

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Guardian Signature, if appropriate

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Relationship to Client

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*(For office use only)*

\_\_\_ Request Denied \_\_\_ Approved as Requested \_\_\_ Approved Per Comments

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Privacy Officer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PO Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Informed in Writing: Yes \_\_\_ Contact Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_