

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

REQUEST DMH SEND THE RESPONSE TO THIS REQUEST TO:

Name

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND/ CORRECT:

PLEASE TELL US WHY YOU THINK THE AMENDMENT OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:

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If we decide to amend/correct the health information as you requested, we will send the amendment/correction to the persons or organizations you identified below. Please identify any other persons or organizations you believe have received your health information and need to be notified of the amendment/correction that you are requesting:

1st Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

2nd Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

INFORMATION ABOUT YOUR AMENDMENT/CORRECTION RIGHTS

DMH will not process your request for an amendment/correction of your health information if it is not made in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.

If DMH denies your requested amendment, we will tell you in writing how to submit a *Statement of Disagreement*, or a complaint, or how to request that we include your amendment request in your health information that we maintain.

Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

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FORM(S) OF IDENTIFICATION PROVIDED:

_____ State Driver’s License	_____
_____ State Identification Card	_____
_____ Birth Certificate	_____
_____ Military ID	_____
_____ Other (Provide details)	_____

_____ Facility	_____ Practitioner	_____ Date
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For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.