REQUEST TO AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name	First	MI	Date of Birth (Mo/D/Yr)	Medical Record #

Street Address	City	State	Zip Code

Select the DHS facility for which this request for amendment applies

☐ LAC+USC Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View-UCLA Medical Center	☐ High Desert Regional Health Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Outpatient Center
☐ CHC/Health Center: _____	
☐ Other: _____	

Facility Name Street Address City State Zip Code

REQUEST DHS TO SEND THE RESPONSE TO THIS REQUEST TO:

Name			Phone Number (include area code)
Street Address			FAX Number (include area code)
City	State	Zip Code	E-mail Address

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND (CHANGE) OR CORRECT:

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

MRUN

NAME

DOB/GENDER

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HS1018 (3-12)

If we decide to amend (change) or correct the health information as you requested, the amendment/correction will be sent to the person(s) or organization(s) you identify below.

1st Person or Organization	Phone Number (include area code)		
Street Address	City	State	Zip Code
2nd Person or Organization	Phone Number (include area code)		
Street Address	City	State	Zip Code

INFORMATION ABOUT YOUR AMENDMENT (CHANGE) RIGHTS

DHS will not process your request for an amendment (change) or correction of your health information if it is not made in writing on this form or does not tell us why you think the amendment is appropriate. We will tell you in writing within 60 days if we will amend or correct your protected health information as you requested, or we will tell you that we need more time (up to 30 extra days) to decide.

If DHS denies your request for amendment (change) or correction, we will tell you in writing how to submit a *Statement of Disagreement,* a complaint, or how to request that we include your amendment request in your protected health information that we maintain.

SIGNATURE OF PATIENT/REPRESENTATIVE:

_____ **DATE:** _____ / _____ / _____
Month Day Year

If signed by other than patient, state relationship and authority to do so:

_____

FOR OFFICE USE ONLY

Form(s) of Identification Provided:

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

Facility: _____
Processed by: _____ Title: _____ Date: _____
Employee Name

For more information about your health privacy rights, ask the facility staff member for a copy of our *Notice of Privacy Practices*. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us/ .

MRUN

NAME

DOB/GENDER

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