

## 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

<input type="checkbox"/> Los Angeles General Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center			
<input type="checkbox"/> Olive View-UCLA Medical Center	<input type="checkbox"/> High Desert Regional Health Center			
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Outpatient Center			
<input type="checkbox"/> CHC/Health Center: _____				
<input type="checkbox"/> 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.

1 <sup>st</sup> Person or Organization	Phone Number (include area code)		
Street Address	City	State	Zip Code
2 <sup>nd</sup> 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:**

<input type="checkbox"/> State Driver's License	<input type="checkbox"/> State Identification Card
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Military ID
<input type="checkbox"/> 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

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