



Los Angeles County Department of Mental Health (LACDMH)

Request to Amend/Correct Health Information

Client Information

Client Name:

DOB:

IBHIS #:

Address:

City:

State:

Zip Code:

Response Delivery Destination

Please tell us where DMH should send the response to this request:

Client Name:

FAX Number (include area code):

Address:

City:

State:

Zip Code:

Phone Number:

Email:

Request Details

Health Information To Amend/Correct: *Attach additional pages if needed*

*Reason for Request (Required): *Attach additional pages if needed*



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Notification Recipients

If approved, identify any additional persons/organizations who should receive the updated information:

1st Recipient Name/Organization:

Address:

City: State: Zip Code:

Phone Number: Email:

FAX Number (include area code):

2nd Recipient Name/Organization:

Address:

City: State: Zip Code:

Phone Number: Email:

FAX Number (include area code):

Amendment Rights & Information

LACDMH 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 LACDMH 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 the other than the client, state relationship and authority to do so:



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Identification Provided (Check all that apply):

☐ State Driver's License:

☐ State Identification Card:

☐ Birth Certificate:

☐ Military ID:

☐ Other (Provide details):

Facility:

Practitioner:

Date:

Contact Information & Notice of Privacy Practices

Please submit your completed form and a copy of your identification by mail, fax, or email to:

Los Angeles County Department of Mental Health
Attn: Health Information Management
510 S. Vermont Avenue, 17th Floor Los Angeles, CA 90020
Fax:(213) 652-1875
Email: DMHHIM@dmh.lacounty.gov

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 <https://dmh.lacounty.gov/our-services/consumer-and-family-affairs/privacy/> or by sending a written request to the address, fax, or email above.

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.