



REQUEST TO AMEND PERSONAL HEALTH INFORMATION

HIPAA PRIVACY

- You have the right to request amendments to your personal health information that we have made and/or maintain. If we deny your request, we will let you know in writing with an explanation of why we are denying it.
- You have the right to submit a written disagreement to our denial. We will put your statement and requested amendment in to your record.
- If we continue to disagree with your amendment request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

To request an amendment, complete this form and mail or return it to:

**Anna Scott
Privacy Officer
163 May St.
Bishop, CA 93514**

Date:

1. YOUR INFORMATION				
Last Name:	First Name:	MI:		
Address:				
City:	State:	Zip Code:		
Email Address:	Daytime Phone:	Evening Phone:		
Best Way to Reach You:		Best Hours to Reach You:		
2. AMENDMENT TO PERSONAL HEALTH INFORMATION				
<p>What type of personal health information do you want to amend?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Medical Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Employment Physical Records <input type="checkbox"/> Alcohol/Other Drug Services Records <input type="checkbox"/> Child Protected Services Records <p><i>[Note: These records are accessible only pursuant to (WIC 827)]</i></p> </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> IMAAA Records <input type="checkbox"/> Billing Records <input type="checkbox"/> Other Health Division Records <input type="checkbox"/> Other <i>(describe)</i> _____ _____ _____ _____ </td> </tr> </table>			<input type="checkbox"/> Medical Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Employment Physical Records <input type="checkbox"/> Alcohol/Other Drug Services Records <input type="checkbox"/> Child Protected Services Records <p><i>[Note: These records are accessible only pursuant to (WIC 827)]</i></p>	<input type="checkbox"/> IMAAA Records <input type="checkbox"/> Billing Records <input type="checkbox"/> Other Health Division Records <input type="checkbox"/> Other <i>(describe)</i> _____ _____ _____ _____
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Please identify the information in your record that you wish to amend, what you want the record to now state, and your reasons for believing the record needs amendment. (You may use additional pages if necessary).

Identify the information in your medical record you wish to amend:

What do you want the record to now state:

Reason(s) you believe the amendment needs to be made:

4. YOUR SIGNATURE

Signature:

Date: