	The Counseling Center of Wayne and Holmes Counties
	Request for Amendment to Health Information

SECTION A: Client to complete the following information.

NAME:_____ BIRTH DATE:_____

ADDRESS:_____

TELEPHONE:_____ DATE:_____

REQUEST:

I hereby request The Counseling Center to amend the following **(check all that apply)**:

- ☐ Medical records for the individual named above.
- ☐ Billing records for the individual named above.
- ☐ Other—please describe _____

Date(s) of information to be amended (*e.g.* date of visit, treatment, or other health care services) _____
_____
_____

The information is incorrect or incomplete in the following manner:
_____
_____
_____

I request this amendment for the following reason(s): _____
_____
_____

The information should be amended as follows: _____
_____
_____

I would like this amendment sent to the following persons who may have received my health information in the past **(please specify name and address of the individuals or organizations)**:

Name_____
Address_____
City/State/Zip_____

Name _____
Address _____
City/State/Zip _____

Name_____
Address_____
City/State/Zip_____

Name _____
Address _____
City/State/Zip _____

Client Name _____ Case Number_____
cc: Medical Records
DSD (01/03) (Rev. 04/04)
(QA 11/04)

I understand that The Counseling Center may or may not supplement the medical record with an addendum based on my request. I also understand that The Counseling Center is not able to alter the original documentation in the medical record under any circumstances. I understand that this request will be made a part of the permanent medical record for the individual named above and will be sent as part of the medical record.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

SECTION B: The Counseling Center to complete the following.

DATE OF RECEIPT OF REQUEST _____

Request for correction / amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

- ☐ The Protected Health Information was not created by this agency.
- ☐ The Protected Health Information is not part of client's designated record set.
- ☐ The Protected Health Information is not allowed to be disclosed.
- ☐ The Protected Health Information is accurate and complete.

Comments:

NOTIFICATION

The client and/or others have been notified of determination via one or more of the following **(check all that apply)**:

- ☐ Notice of Acceptance of Amendment sent to client on [DATE].
- ☐ Notice of Denial of Amendment sent to client on [DATE].
- ☐ Notice of Acceptance of Amendment sent to identified persons pursuant to client authorization on [DATE].

_____ _____

Diane S. DeRue, MPA, LSW Date
Compliance and Privacy Officer

Client Name _____ Case Number_____
cc: Medical Records
DSD (01/03) (Rev. 04/04)
(QA 11/04)