## REQUEST TO AMEND OR CORRECT PROTECTED HEALTH INFORMATION

## King County Behavioral Health and Recovery Division

## The Chinook Building,

## 401 Fifth Avenue, Suite 400

## Seattle, WA 98104

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| Client Name: |  |  |
| Previous Name: |  |  |
| Date of Birth: |  |  |
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I would like to amend part of my protected health information in your records.

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| Information to be amended: |  |
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| If known, where is this information located in your record? |  |
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| Please explain how the information is incorrect or incomplete. What should the entry say to be more accurate or complete? |
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If we agree to make this requested change, would you like this amendment sent to anyone to whom we may have disclosed this information in the past? If so, please provide a written legal authorization to do so. (Authorization forms available on request)

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Signature of client or legal representative Date

(Completed form may be given to site Health Insurance Portability and Accountability Act (HIPAA) officer or mailed to the HIPAA Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

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| **FOR INTERNAL USE ONLY:**  Identity of client verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If signed by a legal representative, authority verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Amendment has been  Accepted  Denied Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If denied, check reason(s) for denial:  BHRD was not the originator of this information and the originator is available to directly act on a request to amend.  The information is not in BHRD records.  The information is accurate and complete.  The information was compiled for use in a legal proceeding.    Name of licensed MHP (print) Title    Signature of licensed MHP Date  Client notified of decision on this date:  (If denied, denial must include statement on client’s right file a disagreement, client’s right to note amendment request and denial on future BHRD disclosures, and client’s right to complain to the secretary.)  Staff person processing request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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