KINGS VIEW

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Client name: _____

Date of Birth: _____ Medical Record #: _____

Please tell us what protected health information you want changed: _____

_____

_____

_____

_____

Please tell us why you want this change. You must give a reason: _____

_____

_____

_____

_____

NOTE: We cannot delete or destroy any information already included in your medical record. We can only add clarifying or correcting statements.

We must tell you within 60 days if we will change your protected health information as you requested, or tell you that we need more time (up to 30 extra days) to decide.

Tell us where to send you a letter: _____

_____

_____

Give a phone number so we can call you: _____

If we decide to change the health information as you requested, we will send the change to any person who received the information before it was changed. Tell us if there are any such persons who need the changed information:

☐ No. Initials _____ ☐ Yes. Initials _____

Please list the persons' names and addresses: _____

_____

_____

_____

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

☐ No. Initials _____ ☐ Yes. Initials _____

We do not have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

_____

_____

_____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

Date: _____ Time: _____ AM/PM

Signature: _____
(Client/legal representative)

If signed by someone other than the client, indicate relationship:

Print Name: _____
(Legal representative)

RETURN this form to the Kings View facility where you receive(d) services.

For more information about your privacy rights-

- See the *Notice of Privacy Practices* available on our website at www.kingsview.org or
- Obtain a copy of the *Notice of Privacy Practices* at the facility where you receive (d) services.

If you believe your privacy rights have been violated, you may file a complaint. ***You will not be penalized for filing a complaint.***

To file a complaint with Kings View, call or write the Privacy Officer. All complaints must be submitted in writing to:

Kings View
Attention: Privacy Officer
7170 N. Financial Drive, Suite 110
Fresno, CA 93720
Phone (559) 256-1080

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

U.S. Department of Health and Human Services
Office of Civil Rights
90 7th Street, Suite 4 – 100
San Francisco, CA 94103
Phone (800) 368-1019
TDD (800) 537-7697