alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date:

Name: Phone Number:

Mailing Address:

Client I.D.: Date of birth:

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.

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: _____

(patient/legal representative)

If signed by someone other than patient, indicate relationship:

Print name:

For more information about your privacy rights, see the Notice of Privacy Practices. You may also receive a copy of the Notice of Privacy Practices by sending a written request to Alameda County Behavioral Health Quality Assurance Office, 2000 Embarcadero Cove, Ste 400, Oakland, CA 94606. If you believe your privacy rights have been violated, you may file a complaint with Alameda County Behavioral Health Care Consumer Assistance office at 800-779-8090 or with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized for filing a complaint.**

When you have finished filling out this form, please return it:

Alameda County Behavioral Health
Quality Assurance Office - Custodian of Records
2000 Embarcadero Cove, Ste 400
Oakland, CA 94606