PLUMAS COUNTY, CALIFORNIA

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date:_____

Name:_____

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:

_____

_____

We must tell you within 60 days if we will change or protected health information as you requested or tell you we need more time (up to 30 days) to decide.
Tell us where to send you a letter:

_____

_____

_____

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. Please tell us if there are any such persons who need the changed information:

☐ No. Initials:_____

☐ Yes. Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

We will also send the amendment to other persons we know received the information before it was changed 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 the 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 created it 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.

Signature of individual or representative:_____

If representative give relationship:_____

When you have finished filling out this form, please send it or bring it to:

_____

_____

_____

_____