REQUEST TO AMEND PROTECTED HEALTH INFORMATION

fox valley PSYCHIATRY 2024

Date: _____

Name: _____

Date of Birth: _____

Medical Record # _____

(if known):

Tell us the manner in which you received your health information:

☐ Healthcare Portal

☐ Signed authorization form

☐ Other: _____

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 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: _____

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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. Please list the persons' names and addresses:

_____ _____

_____ _____

_____ _____

We may deny your request to change your protected health information if:

1. Fox Valley Psychiatry did not create the information.
2. Fox Valley Psychiatry believes it to be accurate and complete.
3. You do not have the legal right to access the protected health information you wanted 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.

If you believe your privacy rights have been violated, you may file a complaint with Fox Valley Psychiatry or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a complaint with Fox Valley Psychiatry, contact: Fox Valley Psychiatry Ltd. Compliance, 4321 W College Ave, Ste 200, Appleton, WI 54914. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

_____ _____

Signature of patient or representative | If representative, give relationship

When you have finished filling out this form, please send it to Fox Valley Psychiatry, Attention: Health Information Management, 4321 W College Ave, Ste 200, Appleton, WI 54914 or bring it to the office to drop it off.