STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE AMENDMENT REQUEST AND DENIAL WITH FUTURE DISCLOSURES

Name: _____ Date: _____

Date of birth: _____

Address:_____

Phone Number:_____

Medical Record #: _____

I understand that UCDHS denied my request to change my protected health information. My request was dated _____.

Mark only one box below:

❒ I want to file this "Statement of Disagreement." I disagree with the denial because:

_____

_____

_____

I understand that the hospital may prepare a written rebuttal to my Statement of Disagreement. A "rebuttal" is a statement of why the hospital thinks my Statement of Disagreement is wrong. If the hospital prepares a written rebuttal, I will receive a copy.

❒ I do not want to file a "Statement of Disagreement," but I want UCDHS to include my amendment (change) request and the denial along with all future disclosures of the information subject to my amendment request.

_____ _____

Signature of patient or representative If representative, give relationship

_____

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with UCDHS, contact the Health Information Management Department at 734-5217. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**