



Request to Amend a Designated Record Set

Last Name:	First:	M.I.:
Other Name(s) Used:		Date of Birth:
Social Security #:	Phone #:	Fax #:
Address:	City:	State: Zip:

I request to make an amendment/correction to the documentation made by:

Staff member: _____ on this date: _____ to the: _____ document or section.

Explanation of requested changes (you may attach a separate page if needed):

I request that copy of the amended document(s) be sent to this individual or agency:

To:	Phone #:	Fax #:
Address:	City:	State: Zip:

We will also send the amendment to other persons that we know have received the information if they relied, or might rely in the future on the information to your detriment or harm.

Spokane Regional Health District may or may not supplement the record with an addendum based on this request. Your request may be denied if:

- We did not create the information or the person who did create it is not available to act on your request to change it;
- The information is, in our judgement, accurate and complete;
- You do not have the legal right to view or access the information you want to change;
- The information is not part of the medical and/or billing records we use to make decisions about your care, treatment, and payment.

Client signature (Parent or Legal Representative, if applicable)

Date

Print Name

Relationship/Authority

**Attach legal documentation if you are the legal guardian or have medical power of attorney*

Internal Use Only:					
Date received:		Received by:			
Date forwarded:		Request forwarded to:		Division:	
<input type="checkbox"/> Amendment accepted. Corresponded with client on this date:					
<input type="checkbox"/> Denied. Reason:					

