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

Date:_____

Patient name:_____

Date of birth:_____Medical Record #:_____

Address:_____

_____

Phone Number:_____

I understand that (name of hospital)_____ 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 Disgreement. 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 (name of hospital)_____

_____ to include my amendment request and the denial along with all future disclosures of the information subject to my amendment request.

Date: _____Time:_____AM/PM

Signature:_____
(patient/legal representative)

If signed by someone other than patient, indicate relationship:_____

Print name:_____
(*legal representative)*

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.mammothhospital.com .

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing.