REQUEST TO CORRECT OR AMEND PROTECTED HEALTH INFORMATION

As a consumer of services with RiverValley Consulting Services, Inc. and its Affiliates, you may request an amendment for inaccurate or incomplete health information maintained in the treatment and billing records that we use to make healthcare and payment decisions about you. If you want to request an amendment, please complete the first page of this form and return it to: ***HIPAA Privacy Office***, ***RiverValley & Affiliates***, ***P.O. Box 1637***, ***Owensboro, KY 42302.***

A response will be issued within sixty (60) days, unless an extension is required and you are notified of the delay and the reason therefore. In no case will the extension be more than 30 days.

Please print the following information.

Consumer name: _____ **Date of Birth:** _____

Parent of Legal Guardian: _____ **Relationship/Status:** _____

Address: _____

Phone number: _____

Please describe the type of entry to be amended, date of entry and the facility location, if known:

_____

_____

Please explain how the entry is inaccurate or incomplete:

_____

_____

Please specify what the entry should say to be more accurate or complete *(you may attach additional information as necessary)*.

_____

_____

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. Initial here: _____
- ❑ Yes. Please list the persons' name and addresses below:

_____ _____

_____ _____

_____ _____

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. Initial here: _____
- ❑ Yes. Initial here: _____

_____ _____

Signature of Consumer or Legal Representative **Date of request**

Legal Representative status or relationship: _____

****

Action/Comments to the Request for PHI Amendment:

Action must be taken within sixty (60) days of the receipt of the request.

____ Request accepted

____ Request denied for the following reason*:

____Information was not created by this organization.

____The information is accurate and complete.

____Information is not part of your designated record set.

____Under the law, you are restricted from accessing or amending this information.

____RIVERVALLEY requests a 30-day extension to respond due to:

_____

Comments from healthcare provider who provided services:

_____

_____

Name of Staff Member Completing Form: _____

Title/Program/Location: _____

_____ _____

Signature of Healthcare Provider Who Provided Service **Date**

rivervalley behavioral health

***** If the request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice, ATTN: **HIPAA Privacy Office, RiverValley & Affiliates, P.O. Box 1637, Owensboro, KY 42302.** If you do not provide us with a statement of disagreement, you may request, **in writing,** that we provide a copy of your original request for amendment and our denial with future disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Office of Consumer Affairs by calling 270-689-6500 or the Secretary of the U.S. Department of Health & Human Services.

On_____(date), _____(name) filed a statement of disagreement to RIVERVALLEY's denial of their request for amendment dated _____.

RIVERVALLEY responds to this statement of disagreement as follows:

_____

_____

_____ _____

Signature and Title **Date**

INTERNAL PURPOSES ONLY:

Date Request Received:_____

Time extension required: _____Yes _____ No

Date of Notification of Decision:_____

Date:_____ Staff initials: _____ All entities notified of Amendment.