REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION (Page 1of2)

Name_______________________________________ Date of Birth _________________ SS#___________________

Address____ Phone ( ) ______________________

I believe that my protected health information described below is incomplete or incorrect. I have listed my reasons why and how the described information should be amended to make the information correct and complete.

Description of the information to be amended, including dates of documentation if applicable:______________________

SCDMH facility, center, clinic, program or office documenting this information: ______________________

Name(s) of SCDMH staff documenting this Information. ______________________

The reason(s) why I believe that the above information is incorrect or incomplete: ______________________

I am requesting that the described information be amended to read as follows:______________________

Signature of SCDMH Consumer Date

REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION (Page 2 of 2)

The following review of the request to amend was completed by ____,
director (or director's designee) of ____ SCDMH operating component.
Consumer ID#:_______________ Date Request Received:______________ Date Request Reviewed:_______________
Name/Title of Staff Reviewing Request:____
____

Was the applicable Information: Created by DMH? __________ Part of the DMH Designated Record Set? ___________
Accurate and Complete? ___________ Was the Consumer's request to amend granted or denied? _________________

If the request to amend is granted: Date Consumer notified:_____________ Date information amended______________
Dates and names of persons notified of amendment:____
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Amendment content: ____
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If the request to amend is denied:
Date Consumer notified:______________. Reason(s) for denial:____
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