REQUEST TO AMEND PROTECTED HEALTH INFORMAITON

Please complete the following if you wish to amend your protected health information held by District Four's Health Care Component. Please print clearly.

Patient Complete Legal Name: _____

Address: _____

Date of Birth: _____ Social Security No. _____ Tel. _____

Original Request Date: _____

- Please request a copy of the medical records that you wish to amend by completing the Authorization for Disclosure form. This form is available at the District's Health Care Component Administrative Office 709 Girod Street, Mandeville, Louisiana, 70478 or by calling (985) 624-8671.

- Please "mark-up" the records that you wish to amend. Please cross out exactly what you want removed or changed. If you want something changed please clearly write exactly how you want the information changed to read. Once the "mark-up" is complete, please return it attached to this document to the address indicated attention Privacy Officer.

- Specifically describe the reason that the protected health information should be amended. If there are multiple amendments, please number them on the "mark-up" and then list the reasons by corresponding number below or on an additional sheet of paper.

Signature: _____ Date: _____
(Patient or Personal Representative)

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE:

Type of authority (e.g., court appointed, custodial parent): _____