REQUEST TO AMEND HEALTH INFORMATION

Return Completed Form by fax or mail to:
Privacy Office
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Denver, CO 80203 Fax: (303) 866-4411
*** Please include copy of your Medicaid ID card and Driver's License, or equivalents ***

The Health Insurance Portability and Accountability Act of 1996 requires that we protect the privacy of your protected health information. You have a right to request that the Department of Health Care Policy and Financing amend your protected health information contained in a designated record set, held by the Department. This request must be made in writing, and may be denied by the Department under certain circumstances. The Department must act on your request within 60 days, unless we provide you with notification in writing that an extension of up to 30 days is needed.

If the Department accepts your request, we must make the appropriate amendment to your Protected Health Information by identifying the records that are affected and appending the amendment to your record. We must inform you of the acceptance and notify all relevant persons or groups that may rely on the amended Protected Health Information.

If the Department denies your request, we must provide you with a written explanation of the basis for that denial. You may submit a written statement disagreeing with the denial, we may then prepare a written rebuttal to your disagreement, which we must provide to you. See the Department's Privacy Policy and Procedures on *Right to Request Amendment of Protected Health Information,* pursuant to 45 C.F.R. 164.526.

CONTACT INFORMATION

Name: _____

State ID number:_____ Date of birth: _____

Address: _____

City, State, Zip: _____

Phone:_____

Signature:_____ Date:_____
Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of an adult. Documentation is required.

If signing on behalf of another person, please fill out the information below:

Name of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

INFORMATION YOU WANT AMENDED: What protected health information in your designated record set would you like amended? Please be specific or attach that portion of your record to this form.

_____

AMENDED LANGUAGE: What amendment would you like to add to your record? Please be specific and include the reason for your amendment request:

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