Statement of Disagreement for Denial of Amendment or Correction of Health Information

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Soc. Sec.#:

I Disagree with the decision to deny my request to amend my protected health information because:

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness (If signed with an "X' or mark) Date

Return this form to: _____

_____

_____

LDH USE ONLY

Date received: _____ ❒ **Rebuttal** ❒ **No Rebuttal**

Comments:

_____ _____
Signature & Title of Agency Representative Date

Sample Form: The Program / Office Mailing Address must be added.