



Response to Statement of Disagreement to Amend Records

Form with fields: Medicaid ID# or Soc. Sec. #, Date Filed, Date Completed, and Insert Client Name and Address

Dear (Client name):

We received your "Statement of Disagreement" in response to our letter notifying you that we denied your "Amendment/Correction of Health Record Request." As part of the amendment request procedure, your initial request, your statement of disagreement, and the supporting documents were forwarded for further review to a third party within our agency who was not involved in the original decision to deny your request.

After considering your initial request, our denial of the request, and your statement of disagreement, along with your medical record, the third party determined that:

- Three checkboxes with corresponding text regarding the amendment request outcome.

If you would like to file a complaint you may contact the \_\_\_\_\_ (Program) Privacy Office at: (Give information here: address, telephone number, and Program's privacy e-mail address.)

Agency Representative and Title Date

c: Case File
Program Privacy Office (i.e. Medicaid, OCDD, OPH, OBH, OAAS)