NOAH
Neighborhood Outreach Access to Health

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Attention: Health Information Management Release of Information
7500 Dreamy Draw, Ste-145
Phoenix, AZ 85020

Phone: 480-882-4545
Fax: 480-882-4594
Email: him@noahhelps.org

PATIENT IDENTIFYING INFORMATION:

Patient Full Name: _____ Date of Birth: ____/____/____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

NAME OF REPORT(S) YOU WANT CHANGED: _____

DATE OF SERVICE(S) WHEN REPORT WAS CREATED: _____

DESCRIBE WHAT PART(S) OF THE REPORT NEEDS TO BE CHANGED: _____

_____

_____

_____

_____

_____

IN YOUR OPINION, WHAT SHOULD THE REPORT SAY TO BE MORE ACCURATE OR COMPLETE AND WHY?
(please provide enough information to support your request for amendment, i.e., eyewitness accounts that support your request, additional medical records from your doctors, etc.)

_____

_____

_____

_____

If your request to the amendment is granted, would you like this information sent to anyone whom we may have disclosed the information in the past? If so, please specify the name(s) and address(es) below.
Attach a form indicating additional names and addresses.

Name of Person or entity	**Address**	**Disclosure Date**

I understand that I may receive a copy of this form and that my request will be processed within 60 days. I understand I will be informed if an extension of not more than 30 additional days is needed to process this request.

I understand that this request for amendment may be denied. If denied, I have the right to submit a written statement of disagreement; or if I do not submit a written statement of disagreement, I understand that I may ask that my request for amendment and the denial be disclosed with any future disclosures of the information that is the subject of the amendment. My statement of disagreement or request for this disclosure should be in writing to NOAH's Health Information Management Department.

I understand that I may file a complaint concerning my request for amendment within 180 days of making the request to the person listed above. I may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.

_____ _____

Signature of Patient — Date

_____ _____

Signature of Parent/Legal Guardian/ Patient Representative
(please attach evidence if appropriate) — Relationship to the patient and your authority to act for the patient