FORM 2515-A

NORTH SOUND MENTAL HEALTH ADMINISTRATION

MEDICAL RECORD AMENDMENT/CORRECTION REQUEST FORM

Consumer Name: ____

Phone Number (day): ____

Phone Number (night): ____

Street or PO Box: ____

City: ____

State: ____

Zip: ____________________

1. Date of Designated Record Set Component or Entry to be Corrected: ______________

2. Language to be Amended/Corrected: _________________________

3. Amendment/Correction: ___________________________________

4. Reason for the Amendment/Correction: _______________________

5. Identify persons who have received the Information (prior to Amendment/Correction):

Name of Organization/Address	Telephone Number
____	__________________________
____	__________________________

6. Do you authorize us to provide the information in Items 3 and 4 above to the persons and organizations listed in Item No. 5?

Yes ______
No, do not provide the information to: ____________________________________

____

TO OUR CONSUMERS: You have the right to submit a Medical Record Amendment/Correction Form to be made a part of your designated record set. This right does not permit you to alter or change the original record created by your health care provider or his/her staff. We may deny your request to amend or correct your records. We cannot amend records that we did not create.

Amendment/Correction Accepted: ___________________

Amendment/Correction Denied: _____________________

Reason for Denial: ____
____
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____
____
____

This Amendment/Correction Sheet Is to Be Made a Part of the Record of:

Consumer Name: ____

Date: ______________________________

Signature of Consumer: ____

You have the right to have an answer to your request within ten days unless the record is in use or there are unusual circumstances. If there are delays you will be told. The delay cannot be more than 21 days from the date after receiving your request. You will receive an answer in writing.

If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in Items # 1 and # 2 above.

Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice of Privacy Practices" or our legal obligations under state or federal law, you may contact the NSMHA Privacy Officer/designee regarding your complaint at (360) 416-7013. You may also file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.