Request for Amendment of Protected Health Information

You have the right to request an amendment of your protected health information maintained by Vecino Health Centers if you believe the information is not accurate or complete. You must submit your request on this form. If the patient is a minor child, the legally authorized representative (e.g., parent) must request the amendment.

Vecino Health Centers may deny your request for an amendment if it does not include a reason to support the request. In addition, Vecino Health Centers may deny your request if you ask Vecino Health Centers to amend information that: (1) was not created by Vecino Health Centers, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of a Vecino Health Centers designated record set, such as the medical record; (3) is not part of the information which you would be permitted to inspect and copy; or (4) Vecino Health Centers determines the original documentation to be accurate and complete. Vecino Health Centers will respond to your request within 60 days, but Vecino Health Centers may also request a 30-day extension which you will be notified of in writing.

Patient name: _____

Date of birth: _____

Mailing Address: _____

City, State, Zip Code: _____

Phone #: _____ Other phone #: _____

Please amend my (or my child's) information as follows:

Date of entry to be corrected/amended: _____

Information to be corrected/amended: _____

Describe what information is incomplete or incorrect and what you believe should be changed. State what information you believe should be added and/or deleted. Use additional sheets if needed and attach to this form.

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State the reason that supports your request. Furnish copies of supporting information, if applicable

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I request that Vecino Health Centers amend my (or my child's) protected health information as maintained by Vecino Health Centers in order to correct inaccuracies or complete the information as described above. I understand that Vecino Health Centers reserves the right to verify my identity.

Signature: _____ Date: _____

Print name: _____ Relationship to patient: _____

If your amendment is accepted, Vecino Health Centers has a responsibility to notify others who are involved in your (or your child's) care and who would rely on the amended information for your (or your child's) well-being. We request that you identify any persons you believe received the related information in the past and who rely on the information to your detriment (or to your child's). By listing a person below, you authorize Vecino Health Centers to notify them of the amendment.

Other persons to be notified about the amendment (attach additional page(s) if necessary):

_____

Name Street City State ZIP

_____

Name Street City State ZIP

_____

Name Street City State ZIP

Mail or fax completed forms to:

Privacy Officer
Vecino Health Centers
5808 Airline Drive
Houston, TX 77076
Fax: 713-695-6929