CEDARS-SINAI MEDICAL CENTER.

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Date: _____

Name: _____

Date of birth: _____

What protected health information do you want amended?

_____

_____

_____

_____

Why do you want this amended? You must give a reason:

_____

_____

_____

_____

The request will be processed within 60 days. We will inform you whether your protected health information was modified as you requested, or that we need additional time (up to 30 extra days).

Where to mail correspondence:

_____

_____

_____

_____

Give a phone number so we can call you: _____

If we decide to modify the health information as you requested, we will send the modification to any person who received the information before it was modified. Tell us if there are any such persons who need the modified information:

❑ No. Initials: _____

❑ Yes. Please list the person(s) names and addresses:

_____ _____

_____ _____

_____ _____

(Continued on Back)

We will also send the amendment to other persons that we know received the information before it was amended if they relied, or might in the future rely, on the information to your detriment (harm). Do you agree to this?

- ❑ No. Initials: _____
- ❑ Yes. Initials: _____

We do not have to amend your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to amend it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain: _____

   _____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want modified.
4. The protected health information you want amended is not part of the designated record set. This includes your medical records, billing, and records containing your protected health information that are used by us to make decisions about you.

For more information about this form and its contents, please contact the Health Information Manager at (310) 248-6674.

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at **www.csmc.edu**, contact the Cedars-Sinai Medical Center Privacy Manager at (323) 866-7877, or send a written request to Privacy Manager, Cedars Sinai Medical Center, 8700 Beverly Boulevard, Los Angeles, CA 90048.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Medical Center, contact the Privacy Manager at (323) 866-7877. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

_____

Signature of patient or representative

_____

If representative, (give relationship)

When you have finished filling out this form, please send it to:
Cedars-Sinai Medical Center
Health Information Department
8700 Beverly Blvd. - Suite 2901
Los Angeles, Ca 90048
Attn: Release of Information