COUNTY OF MARIN

HIPAA Health and Medical Information Privacy Program

REQUEST TO AMEND HEALTH RECORD

You have the right to request amendments to your personal health information held by the County of Marin. To request an amendment to your health information, complete this form and mail or return it to:

County of Marin – Privacy Program
c/o Department of Health and Human Services
20 North San Pedro Road, Suite 2028, San Rafael, CA 94903
Phone: (415) 473-2087 / Fax: (415) 532-2627 / E-mail: HIPAA@marincounty.org
If your hearing is impaired call the California Relay Service: (800) 735-2929

		DATE:	HIPAA FILE NUMBER: (FOR HIPAA OFFICE ONLY):

Enter Client's/Individual's Information

LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
SOCIAL SECURITY OR IDENTIFICATION NUMBER:	COUNTY IDENTIFICATION OR RECORD NUMBER:	DATE OF BIRTH:	
ADDRESS:		CITY/STATE:	ZIP CODE:
EMAIL ADDRESS:	DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	
BEST WAY TO REACH YOU:	BEST TIME TO REACH YOU:		

Enter Representative's Information

NAME OF REPRESENTATIVE	ROLE ☐ PERSONAL REPRESENTATIVE ☐ PARENT ☐ GUARDIAN ☐ OTHER _____		
ADDRESS:		CITY/STATE:	ZIP CODE:
EMAIL ADDRESS:	DAYTIME TELEPHONE NUMBER:	EVENING TELEPHONE NUMBER:	
BEST WAY TO REACH YOU:	BEST TIME TO REACH YOU:		

VERIFICATION: The County does not want someone to access your health information without your permission. Before we will review your request, you will need to verify your identity by providing one acceptable form of picture identification. An acceptable identification includes a California State Identification, California State Driver's License, U.S. Passport (unexpired or expired), unexpired foreign Passport with I-551 stamp or attached INS Form I-94, Tribal Identification Card, Alien Registration Receipt Card with photograph (INS Form I-151 or I-551) or Mexican Consular Card. **If you mail in this request, you will be required to attach a copy of your picture identification or if you drop off this request, you will be asked to present your picture identification at that time.**

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VERIFICATION for Personal Representative: If the signer of this request is a guardian or legal custodian of an adult, minor, emancipated minor or a representative of a deceased client and is authorized by state law to act on behalf of the client in making decisions about health care, a copy of the legal authority (guardianship or custody order) must be attached to this form. If the signer of this request is a personal representative and does not have formal legal authority to act on behalf of the client, the client must provide documentation, in writing, that appoints the person making the request as his/her personal representative. The documentation must be attached to this form.

Your Rights:

- You have the right to request amendments to your health information held by the County of Marin (Fire Department and Department of Health and Human Services Divisions of Aging, Alcohol, Drug and Tobacco Programs, Community Mental Health Services, Health Services, and/or Office of Finance).
- You have the right to receive a written response to your request within 30 days.
- If there is a delay in responding to your request, you will be notified in writing. The delay cannot be for more than 30 days.
- If you disagree with the County's response to your request, you can provide a written statement that describes how you would like your record to be amended (changed). The County of Marin is required to keep your statement with your record. Your statement, or a summary of it, will be included in future disclosures or your personal health information made by the County.
- The County of Marin may also provide a written response to your statement. The County's statement will also be placed in your record. The statement will also be included in future disclosures of your personal health information made by the County. You may request a copy of the County's written response to your statement.

When requesting an amendment or a change to your record, please consider:

- The County of Marin cannot amend records that were not created by the County (*unless it can be shown that the originator of the information is no longer available*)
- The County of Marin will only amend records if they are found to be incomplete or inaccurate
- The County of Marin cannot amend information if it is not part of the records the County maintains
- Please attach to this form any information you have to support your request

Explain the amendment(s) or change(s) you want to make to your health information.

Explain what you want the information to state.

Explain the reason(s) why you want to make this amendment or change.

List the program(s) or people that you know received your health information that you want changed. Also identify who needs this amendment or change documented (if known).

PROGRAM/PERSON:		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PROGRAM/PERSON:		
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TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

PROGRAM/PERSON:		
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:	CONTACT NAME (IF KNOWN):

Individuals can file privacy complaints with either the County of Marin or with the U.S. Department of Health and Human Services, Office for Civil Rights. For more information please contact:

County of Marin - Privacy Officer
c/o Department of Health and Human Services
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Phone: (415) 473-2087/ FAX: (415) 532-2627 / E-mail: HIPAA@marincounty.org
You can call the California Relay Service if your hearing is impaired: (800) 735-2929

To get a copy of this form in other languages or an alternative format in compliance with the Americans With Disabilities Act, please call or write the County of Marin's Privacy Officer.

Signature and Identity Verification

SIGNATURE (CLIENT OR PERSONAL REPRESENTATIVE):	DATE:
IDENTIFICATION TYPE PRESENTED TO VERIFY IDENTITY (TO BE COMPLETED BY COUNTY EMPLOYEE):	
NAME AND LOCATION OF THE COUNTY EMPLOYEE THAT RECEIVED THIS REQUEST:	
IDENTITY VERIFIED BY (COUNTY EMPLOYEE SIGNATURE):	DATE: