Request to Amend Protected Health Information

Description: This form is used to request a change to the protected health information that Travis County maintains.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you the right to request an amendment of any protected health information that Travis County maintains in a designated record set. If you believe that any portion of the protected health information that Travis County maintains is incomplete or inaccurate, complete this form and return it to:

HIPAA Compliance and Privacy Office
700 Lavaca, Ste. 400
Austin, TX 78701

You may also email a scanned form to:
privacy@traviscountytx.gov

Please note that Travis County will deny your request for amendment of protected health information when:

- The information was not created by Travis County, unless the person or entity that created the information is no longer available to make the amendment and you provide the County with documentation to this effect.
- The information is not part of a designated record set, such as the medical or billing record.
- Inspection or copying of the information is prohibited by law.
- The County determines that the information in the designated record set is accurate and complete.

Part I: Requestor's Information

Name: _____

Date of Birth: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Email Address: _____

If you are acting on someone else's behalf (for example, the subject of the designated record set), provide the name and address of the person on whose behalf you are requesting and describe and provide proof* of your legal relationship with the individual. Recognized legal relationships include: parent of minor child, legal guardian, power of attorney, or executor.

Name: _____

Address: _____
Street City State Zip Code

Relationship to Individual: _____

Travis County will accept documentation such as an executed will, power of attorney, or court order as proof of your legal relationship. You must also furnish a valid government issued picture ID.

Part II: Information about Designated Record Set

Travis County Component* which maintains the records subject to this request:_____

** *A list of the covered components within Travis County is available from the HIPAA Compliance and Privacy Officer or on the Travis County web page* ***https://www.traviscountytx.gov/hipaa.***

Type of record to be amended:

- ☐ Discharge Summary
- ☐ History/Physical Exam
- ☐ Consultation Reports
- ☐ Past/Present Medications
- ☐ Progress Notes
- ☐ Other_____
- ☐ Billing (Claim) Information
- ☐ All health Information
- ☐ Mental/Behavioral Health Records - (May Require Psychologist Approval)

Date of the entry or information to be amended: _____

Part III: Request

Describe what information you believe to be incomplete or incorrect and how you would like it to be changed.

_____

_____

_____

State the reason(s) that support your request. If applicable, furnish copies of supporting information.

_____

_____

_____

Part IV: Important Information about This Request

- Travis County will only consider this request if you provide a reason to support it.
- Travis County will act on this request within 60 days. If Travis County cannot act on your request within this timeframe, we will write to inform you of the reason for the delay and the date by which you can expect that the request will be completed.
- If your request for amendment is approved:
  - the amendment will be appended or linked to the information or record that is being amended.
    The information, as originally displayed in the record, will not be changed or deleted
  - Travis County has a responsibility to notify others who are involved in your care and who would rely on the amended information for your well-being.

- If your request is denied, Travis County will notify you in writing of the denial, and you may:
  - submit a written statement disagreeing with the denial
  - request that your original request to amend and denial be attached to any future disclosures of your medical information
  - file a complaint with the Travis County HIPAA Compliance and Privacy Officer, whose contact information is listed above, or with the U.S. Secretary of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20101, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Part V: Acknowledgement

By signing this form, I authorize Travis County to send notice of any amendment made as a result of this request to those persons or entities to whom Travis County has previously disclosed such information and who may have or could foreseeably rely on such information.

_____ _____

Signature of Requestor *Date*

Part VI: Additional Information

Please provide the names of any other persons or entities to whom we should send notice of an amendment. At a minimum, you should identify any persons who have received the information in the past and who may rely on the information in making decisions about your treatment or payment for healthcare**:**

_____

_____

_____

Please provide the address where Travis County should send written correspondence about this matter:

Address:_____

Street City State Zip Code

Email: _____

FOR
OFFICE
USE ONLY

Date Received: _____
Received by: _____ Title: _____
Date Forwarded to Privacy Liaison: _____

Deadline to Respond: _____

Verification of Requestor's Identity: ☐ Photo ID ☐ Identifying Information ☐ Matching Signature ☐ Other: _____	If the request was submitted by a Personal Representative, the authority of the Personal Representative was verified by: ☐ Executed Will ☐ Documentation of Power of Attorney ☐ Signed Authorization by the Individual ☐ Other: _____
Amendment is: ☐ Accepted—all ☐ Accepted— in part ☐ Denied Date notification sent to individual: _____	If the request was <u>approved</u>, was the ☐ Medical record amended? ☐ Amendment sent to other providers? If the request was <u>denied</u>, for what reason? ☐ the information was not created by Travis County ☐ it is not part of the medical or billing record. ☐ inspection of the medical information is prohibited by law. ☐ the record is accurate and complete.
Was a Statement of Disagreement submitted? ☐ Yes ☐ No	