Statement of Disagreement with Amendment Request Determination

Client Name: ____________________________

Contact information: *(phone, email, and/or physical address):* ______________________________

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Date of Birth: ____________________________

Today's Date: ____________________________

Didi Hirsch Mental Health Services has denied my request to amend protected health information within my record. I disagree with the denial for the reasons indicated below:

I acknowledge that this Statement of Disagreement will be included in my formal client record and will be included with future disclosures of the PHI in question.

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Signature of Client / Personal Representative/Caregiver **Date**

If signed by someone other than the client, state relationship:

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For more information about your health privacy rights, contact us or Patient's Rights Office.

Didi Hirsch Mental Health Services **Privacy Officer** 4760 S. Sepulveda Blvd. Culver City, CA 90230 compliance@didihirsch.org	**DMH Patient's Rights Office** Los Angeles County Department of Mental Health 550 S. Vermont Ave., 5th Floor Los Angeles CA 90020 (213) 738-4888