SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
HEALTH INFORMATION SERVICES DEPARTMENT

REQUEST TO REVIEW, AMEND OR RESTRICT PROTECTED HEALTH INFORMATION

According to the Public law 104-191 of the Health Insurance Portability and Accountability Act of 1996 that you have the right to the following:	Also, we may deny your requests if:
• **Access to protected health information** • **Accounting for disclosures of protected health information** • **Access to disclosure log** • **Amend protected health information** • **Request restrictions on released Health Information**	• **The Protected Health Information was not generated by SNAMHS** • **The Protected Health Information is not part of your record** • **If your physician has determined that the change/addition is likely to harm you or another person** • **The Protected Health Information is incomplete**

I_____,_____DOB: / /

☐ **WOULD LIKE TO RESTRICT MY PERSONAL HEALTH INFORMATION AS FOLLOWS**:

_____

_____

☐ **REQUEST TO REVIEW MY RECORD**:

REASONS:_____

_____

☐ APPROVED
☐ DENIED (The back of this page must be completed by the treating physician if this box is checked)

Reviewed on: _____ _____
Date Client Signature

Witness: _____ _____
Printed Name and Title Signature

☐ **I REQUEST TO AMEND MY RECORD**:

INFORMATION TO BE REVIEWED OR AMENDED IS LOCATED IN:

☐ Consultation Reports	☐ Diagnosis (psychiatrist)	☐ Progress Notes
☐ History & Physical Exam	☐ Discharge Summary	☐ Labs
☐ Treatment Plans	☐ Psychiatric Evaluation	☐ HIV/AIDS Info.
☐ Psychological Assessment	☐ Medication Records	☐ Drug and Alcohol Abuse info

Other (Specify):----------

I REQUEST TO AMEND MY RECORD AS FOLLOWS: (Be Specific. Use an additional page if necessary.)

_____

_____

_____

REASONS:_____

_____

_____

Date Client Signature Legal Guardian Signature Witness Signature

☐ APPROVED DATE CHANGED: _____
☐ DENIED (The back of this page must be completed by the treating physician if this box is checked)

Name: _____

File #: _____

☐ **I REQUEST TO REVIEW RECORD**: ☐ DENIED

REASONS:_____

_____

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_____

_____

Date Physician Signature Printed Name

As a result of this denial the treating team is responsible to ensure the following: (Please check the box, sign and date if you were the individual responsible to complete.)

	Activity	Signature	Date
☐	Informed the client or rights and grievances procedures & documented in the medical record		
☐	Filed a denial of rights		

Client initiated a grievance: ☐ Yes ☐ No Date:_____

☐ **REQUEST TO AMEND RECORD**: ☐ DENIED

REASONS:_____

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_____

_____

_____

_____

Date Physician Signature Printed Name

As a result of this denial the treating team is responsible to ensure the following: (Please check the box, sign and date if you were the individual responsible to complete.)

	Activity	Signature	Date
☐	Informed the client or rights and grievances procedures & documented in the medical record		
☐	Filed a denial of rights		

Client initiated a grievance: ☐ Yes ☐ No Date:_____

Comments:

Name: _____

File #: _____