ATTACHMENT B

USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE CORRESPONDENCE

LETTER RESPONDING TO REQUEST TO AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION

Patient Name
Address

Date

Date of Birth:
Medical record number:

Dear

Thank you for submitting to us your ***Request to Amend (Change) or Correct Protected Health Information***. Your request was forwarded to the responsible practitioner for review. We received your request to (change) or correct your protected health information dated: {date}.

We have determined that:

- ❑ We will make the change as you requested and will notify the person(s) you designated of the change.
- ❑ We need more time to process your request. We will send you a response to your request by_____.

REASON FOR PARTIAL DENIAL (IF APPLICABLE)

- ❑ We will make the change that you requested, but only in part, and will notify the person(s) you designated of the change.
    - ○ The part of the change that we will make is: {specify}
    - ○ The part of the change that we will not make is (include reason):

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REASON FOR FULL DENIAL (IF APPLICABLE)

Your request to change your protected health information is denied because:

- ❑ You did not include a reason to support your request.
- ❑ The information we have is deemed accurate and complete.
- ❑ We did not create the information you want changed, and you did not give us a reasonable basis to believe that the originator of the information is no longer available to act on your request to change the information.
- ❑ The information you want changed is not information that you have a right to access.
- ❑ The information you want changed is not part of the designated record set. This means your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.
- ❑ Other:

YOUR RIGHTS IF WE DENIED YOUR REQUEST TO AMEND (Change) (If Applicable)

If we denied your request to change your protected health information, in whole or in part, you may submit a "**Statement of Disagreement"**. If you do not want to submit a Statement of Disagreement, you may ask us to include your amendment (change) request and our denial along with all future disclosures of the information that you wanted changed by completing the appropriate section on the ***Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures*** form.

If you want to submit a ***Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures***, please request the form from the Health Information Management Department (Medical Records Department). Return the completed form to Health Information Management Department (Medical Records Department).

Health Information Management
LAC+USC Medical Center
1200 N. State Street, Room 337
Los Angeles, CA 90033

For more information about your health privacy rights, ask a staff member for a copy of our ***Notice of Privacy Practices***. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us/.

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County, or the Federal Government. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

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HIPAA Compliance Office
LAC+USC Healthcare Network
1200 N. State Street,
Los Angeles, CA 90033

Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012
800-711-5366

Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us

To file a complaint with the Federal Government, contact:

Region IX, Office of Civil Rights
US Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
(415) 437-8310
(415) 437-8329 (Fax)
(415) 437-8311 (TDD)

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care needs.

Sincerely,

HIPAA Compliance Officer