



## DEPARTMENT OF MENTAL HEALTH

Patient's Right Division  
550 S. Vermont Ave., 5<sup>th</sup> Floor  
Los Angeles, CA 90020

### LETTER RESPONDING TO REQUEST TO AMEND/CORRECT HEALTH INFORMATION

Date of Birth:  
MIS #:

Dear

Thank you for submitting to us your **Request to Amend/Correct Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your request to amend/correct your protected health information dated.

We have determined that:

- We will make the change as you requested and will notify the persons 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 persons you designated of the change.
  - The part of the change that we will make is:
  
  
  
  
  
  
  
  
  
  
  - The part of the change that we will not make is (include reason):



**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 (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 Treatment Team. After completing the form, return it to the Treatment Team or mail it to:

**Los Angeles County Department of Health Services (LACDHS)  
Patient's Rights Division  
550 South Vermont Avenue  
Los Angeles, CA 90020**

You have the right to submit a complaint to the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:



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**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](mailto:CIPO@cio.co.la.ca.us)**

To file a complaint with the Federal Government, contact:

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

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Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

Department of Mental Health  
Los Angeles County