GRANT COUNTY FIRE PROTECTION DISTRICT NO. 3
Request to Correct or Amend Health Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

Patient Mailing Address: _____

☐ **I request a change to my records.**
Please explain what the Health Information in your record should say to be more accurate or complete. If you need additional space, please include a separate page.

_____

_____

_____

Patient or legally authorized individual signature Date

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

We will review your request and respond within 10 days of receiving your request. A copy of your request will be added to your record. **Date of entry in record:_____**

We will send changes to:
anyone you identify, and anyone who received the information in the past and who needs to know about the change.

To be completed by District Privacy Officer

Date Received: _____ Correction/Amendment has been: ☐_ Accepted ☐_ Denied

☐ The review of this request for correction/amendment has been delayed. Your request will be processed by the following date: _____ (not later than 21 days after the request).

If denied, check reason for denial:
- ☐ The existing Health Information is accurate and complete.
- ☐ This request does not pertain to the patient's medical and financial records.
- ☐ Due to federal and state laws this Health Information is not available.
- ☐ This Health Information was not created by this organization.
- ☐ The record no longer exists or cannot be found.
- ☐ The record is not maintained by this organization.