COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY®

Statement of Disagreement for Denial to Amend my Protected Health Information Form

Patient Information	
Patient Name:	Submitted Date:
Street Address:	Birth Date:
City/State/Zip:	Telephone #:
Patient's Personal Representative Name:	

I disagree with the decision to deny my request to amend my protected health information because:

Date: _____

Signature of Patient _____

Signature of Patient's Personal Representative_____

Printed Name of Patient/Personal Representative_____

FOR CHSLV INTERNAL USE ONLY

Disagreement Form Received:__/___/___/	❑ Final Review Completed within 30 days ❑ Written Rebuttal Sent:___/___/___/

_____ _____/_____/___
Signature of Practitioner Date

_____ _____/_____/___
Signature of CHSLV Privacy & Security Officer Date