Amendment Request

Wyoming Department of Health

As required by the Health Insurance Portability and Accountability Act of 1996, clients have a right to request an amendment to health information pertaining to them if it is believed to be incorrect or incomplete. WDH will review and make a determination granting the request or explaining why it will not be granted. If the request is not granted, a client has a right to submit a statement of disagreement to accompany the information in question for all future disclosures. WDH may place a response to the statement in the record.

For Office Use Only:

I hereby request an amendment to health information for:			☐ Delayed, we will act on this request by		
Name: ID Number:			Comments:		
Address:	Date of Birth:				_
Record Holder:	Date of Request:				
WDH may not amend information if:		WDH Representative Signature: Documentation of Relationship: □ Reviewed □ Attached			
✓ It does not involve the client's me ✓ If it involves records the client doe ✓ WDH is not the creator of the info ✓ WDH believes the information is a	es not have a right to access rmation (unless the person	ss; n or entity that created the ir	-		
If WDH agrees to amend the information before it was amended.	n, the changed informat	tion will be communicated	to the persons or entition	es WDH has provided t	he information to
Client Statement: I believe health information for the above	named individual is incor	rect or incomplete and reque	est the following amendn	nent:	_
Signed:	Print Name:		Telephone:	Date:	_
If not signed by the patient, please indicate ☐ Guardian or conservator of an incomp ☐ Parent or guardian of minor client			ıl representative of decea		
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