South Carolina Department of Social Services

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

NOTICE: Individuals may seek to amend their protected health information (PHI) in their client files. The original information in the file will not be erased or obliterated as a result of this amendment if approved.

Date of record: _____

I believe my records should be amended as follows: _____

_____

_____

_____

_____

My reason for amending my record is: _____

_____

_____

I request that the following person(s) be notified of the amendments to my protected health information.

_____

_____

_____

_____

_____

_____ _____

Signature of Individual or Representative Date

_____

Printed Name

_____

Relationship to Client