IOWA Health and Human Services

Request to Amend Health Information

Name of Client	Date of Request
Mailing Address – Street or P.O. Box	State ID

City, State, and Zip Code	Phone Number	Date of Birth

Email Address	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone

Check all the programs that apply:

☐ Medicaid ☐ Hawki ☐ Woodward Resource Center

☐ Cherokee Mental Health Institute ☐ Independence Mental Health Institute

To be completed by the client or client's personal representative

I request that the Iowa Department of Health and Human Services (Department) amend the following health information in my record. I understand that I can expect an answer in 60 days unless the Department writes to me, giving me the reasons more time is needed (up to 30 more days).

I understand that the Department is not required to agree to my request, but if it does agree, the Department will make the amendments as requested and will provide them to the persons I have identified and to other persons who may have relied on the information to my harm.

I also understand that if my request is not approved, I may appeal the denial of my request. If I lose my appeal, the Department will attach information regarding my request and the appeal to my record.

If I disagree with the Department decision, I may file an appeal with the Department following the directions provided to me in the decision documentation.

If I do not appeal, I may ask the Department to include my request and the Department's decision with any future releases of the information, and the Department will do so.

(Be specific about the answers to these questions. Attach additional pages if necessary.)

I would like the following health information amended: *(Name the subject of the information. Give the dates of the information. It cannot be before April 14, 2003.)*

_____

_____

I want this information amended as follows: _____

_____

I want this information amended because: _____

_____

I want this amendment sent to: (Name of person or agency and address): _____

Client or Personal Representative Signature	Date
Representative Printed Name	Relationship to Client

To be completed by Privacy Officer	
☐ Request is granted. Should the Department need to stop honoring your request to change how information is provided, we will send you a written notice. ☐ Request is denied. Reason for denial: _____	
Manual and Rule Reference:	
Privacy Officer Signature	Date