WellPower

Request to Amend Health Record

DM Reference #:

The completed form can be returned to the HISM Department by email at **HISM@wellpower.org**, by fax at **(303) 504-6504**, or in person/by postal mail **attention to HISM** at **4141 East Dickenson Place (Office 170), Denver, CO 80222**.
If you have any questions, please call HISM at (303) 504-6510.

Person Served Information

Please complete the following information about the person whose health records an amendment is being requested.

First Name: _____ M.I.: _____ Last Name: _____

WellPower ID#: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Requestor Information

(if applicable)

If you are requesting amendment on behalf of the person in services, please fill in your information below. Supporting documentation of your legal authority to make this request must be included. Leave blank if not applicable.

First Name: _____ M.I.: _____ Last Name: _____

Organization: _____ Relationship: _____

Your Contact Information

Street Address: _____ City, State: _____ Zip: _____

Email: _____ Phone: _____

I am requesting the following change(s) to my health record:

I am requesting this change because:

I understand that my request will be considered but may not be granted. I understand that I will be notified of the decision in writing. I further understand that this request will become a permanent part of my health record.

If my request is accepted, I understand that I must identify other persons who maintain health information about me who need to be informed of the amendment. WellPower will also identify other persons or entities who need to be informed of the amendment.

If my request is denied, I understand that I can write a statement of disagreement and request that the denial and statement of disagreement be included in any further PHI disclosures.

X _____ _____

Requestor Signature Signature Date