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	*Phone Number*
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 LAMOILLE HEALTH PARTNERS INTERNAL USE ONLY	
Disagreement Form Received: (mm/dd/year)	☐ Final Review Completed within 30 days
	☐ Written Rebuttal Sent: *(mm/dd/year)*

Signature of Practitioner	*Date (mm/dd/year)*

Signature of Lamoille Health Partners Privacy & Security Officer	*Date (mm/dd/year)*

Origin 07/26/2016
Form 500.332D