



**Note:** Include copies of documents that provide your authority as a substitute decision-maker.

**PART B: CORRECTION REQUEST**

**(1)** List or attach the correction(s) requested, with reasons for the correction(s):

Requested Correction(s)	Reasons for Correction(s)

**(2)** Would you like us to give notice of the correction(s), to the extent reasonably possible, to others to whom we have disclosed the incorrect information? (We will only do so if this notice will affect your health care or otherwise benefit you.)

Yes                       No

\_\_\_\_\_  
Requestor's Signature

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Date

**PART C: CORRECTION REQUEST RESPONSE (For Internal Use Only)**

- Correction(s) made
- Correction(s) not made
- Refusal letter (with reasons) sent
- Statement of Disagreement attached to record
- Other
- Date of Response \_\_\_\_\_

**(1)** List names, contact information and comments of any individuals consulted:

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**(2)** If correction was not made, provide reasons:

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**(3)** If an extension to the correction request response was required, please indicate:

Date of Extension	Reason for Extension	Date Patient Notified of Extension

**(4)** List names of those to whom a notice of correction has been sent:

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**(5)** Processed by:

\_\_\_\_\_  
Signature                      Name (print)                      Title

*All information provided on this form will be used and disclosed in compliance with the Personal Health Information Protection Act.*