Health Record Amendment Request Form

You have the right to request to amend health information we maintain about you or your child if you believe the health information is inaccurate or incomplete. Please note, this does not include routine changes such as change of address or phone number.

All of the fields below must be completed. If left blank, this could lead to delay in the processing of your request. If the client is a minor, the legally authorized representative must complete this form. If the client is an adult, they must complete the form themselves.

Email the completed form to records@foundation2.org. No later than **60 days** after you submit this completed form, you will receive a written response to your request via email from Foundation 2 Crisis Services.

Client First Name:	
Client Last Name:	
Client Date of Birth:	

Name of Person Requesting Amendment:	
Relationship to Client:	☐ Self ☐ Mother ☐ Father ☐ Legal Guardian ☐ Power of Attorney ☐ Personal Representative ☐ Other (please specify):
Address:	
City:	
State:	
Zip:	
Phone Number:	
Email Address:	
Driver's License/State ID #: (*please provide a copy with request*)	

Preferred method of contact: *(this is how we will follow-up with you on the outcome of your amendment request)*	☐ Secure Email ☐ Fax ☐ Mail

Please tell us what health information you would like us to amend. Be as specific as possible regarding the record type, date: (*use additional sheets as needed provide a copy with request)*	
Please tell us what the amendment should be: (*explain what changes should be made or information added)*	
Please tell us the reason for the amendment request: (*Why do you believe this information should be corrected or updated?)*	

Supporting information (optional): (*Provide any documents or other information that supports your request:*	

Release of Information:

If the amendment is accepted, you may request that we notify others that you believe received the information in the past. By providing names below, you authorize Foundation 2 Crisis Services to notify them of the amendment/addendum.

Name and/or Organization:	
Address:	
Phone:	
Fax:	

Authorization

I understand that Foundation 2 Crisis Services may accept or deny my request. If denied, I have the right to submit a written statement of disagreement, and this request will be included with future disclosures of my record.

Signature of Client/Legal Representative: *(By signing, I affirm that I am the client's representative/guardian and have the authority to authorize who may access their health information and to review and/or request changes to the client's health information.*	
Printed Name:	
Relationship to Client:	
Date:	

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For Foundation 2 Crisis Services Use Only:

Date Received:	
Reviewed By:	
Decision:	☐ Accepted ☐ Denied
Date of Response to Client/Representative:	
Notes/Comments:	