Patient Name:_____ DOB:_____

Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (_____)_____ Work Phone: (_____) _____

Medical Record Number:_____ E-mail: _____

Statement of Disagreement:

_____

_____

_____

_____

_____

_____

Patient or Legal Representative Signature:_____

Relationship to Patient: _____ Date:_____ Time:_____

- You may request that Parkview Health provides your request for amendment and the denial with any future request for information.
- If you want more information about our privacy practices, have questions or concerns, or believe that we may have violated your privacy rights, please contact: **260-373-3760**.
- You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address upon request. We support your right to protect the privacy of your medical information. We will not retaliate in anyway if you choose to file a complaint.

PARKVIEW HEALTH

- ❑ Parkview Regional Medical Center
- ❑ Parkview Hospital Randallia
- ❑ Parkview Huntington Hospital
- ❑ Parkview LaGrange Hospital
- ❑ Parkview Noble Hospital
- ❑ Parkview Ortho Hospital
- ❑ Parkview Wabash Hospital
- ❑ Parkview Whitley Hospital
- ❑ Parkview Physicians Group

All entries must be dated and timed.

PATIENT STATEMENT OF DISAGREEMENT