SUNY DOWNSTATE Medical Center

EXTENSION NOTIFICATION

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For Amendment Of Health Information

Dear [Patient Name]:

This letter responds to your request that we amend your health information, which we received from you on _____.

We have been working hard to determine whether we can grant your request. We are usually able to process requests within 60 days. However, for the following reason(s), we need an additional 30 days to respond to your request:

- ❑ We are still working to access the information that you would like amended.
- ❑ We are still preparing the amendment you requested.
- ❑ We are working to verify whether the information is inaccurate and incomplete without the amendment you requested.
- ❑ We need more time because _____.

We expect to have a final answer for you no later than _____. If additional time is required, we will notify you again.

Please contact the _____ Department of SUNY Downstate Medical Center University Hospital of Brooklyn at (718)270-_____ if you have questions or concerns about this delay.

Sincerely,

_____ Department

SUNY DOWNSTATE Medical Center

NOTICE OF APPROVAL OF AMENDMENT

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For Amendment Of Health Information

Dear [Patient Name]:

This letter responds to your request that we amend your health information, which we received from you on _____. We agree to make the amendment that you have requested. Your records will be updated accordingly.

If you agree, we will also notify other people or organizations about this amendment that may rely on the original un-amended information they currently have in a way that may negatively affect you. In addition, we will notify others that you identify that may have the original un-amended health information.

Please check the appropriate box(es) below and return within 10 days to:
SUNY Downstate Medical Center University Hospital of Brooklyn
Department of _____- Box #_____
Correspondence Unit
450 Clarkson Ave.
Brooklyn, NY 11203

As always, we are committed to helping you assure that the information about you is kept accurate. Thank you for your assistance and patience in helping us achieve this goal.

TO BE COMPLETED BY THE PATIENT:

- ❑ Notify others that SUNY Downstate knows has my original health information that can negatively affect me.
- ❑ Notify others whom I know have the original information. Specify name(s), address and phone number(s):

  _____
  _____
  _____
  _____

_____ _____
Signature of Patient or Personal Representative Date

SUNY DOWNSTATE Medical Center

NOTICE OF DENIAL LETTER

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Denial of Request To Amend Health Information

Dear [Patient Name]:

This letter responds to your request that we amend your health information, which we received from you on _____. For the reasons stated below, we are denying your request:

- ❑ The request was not in writing.
- ❑ The request did not explain why you believe we should make the amendment.
- ❑ The information you would like to have amended is not available in records that we use to make decisions about you or your treatment.
- ❑ The information you would like to have amended was not created by SUNY Downstate. You may wish to ask the person or organization that created the information for an amendment.
- ❑ The information you requested cannot be amended because you are not entitled to inspect this information. The reason you are not entitled to inspect the information is _____.
- ❑ We believe that the information is not inaccurate and incomplete without the amendment you requested.

You have the right to submit a statement explaining your disagreement with our decision to deny the amendment you requested. This statement must be in writing and should be no longer than two (2) pages. We will include your statement, or an accurate summary of it, any time we disclose to others the protected health information that you think should have been amended. However, we reserve the right to prepare a response to your statement of disagreement, called a rebuttal statement, which we may also include when we make future disclosures of the information that you think should have been amended. If you wish to exercise this right, please send your statement of disagreement to:

SUNY Downstate Medical Center University Hospital of Brooklyn
Department of _____- Box #_____
Correspondence Unit
450 Clarkson Ave.
Brooklyn, NY 11203

If you do not submit a statement of disagreement, we will include only your amendment request and this denial notice in any future disclosures of the information which you think should have been amended.

We hope that you will understand the reason that we have denied the amendment you requested. However, if you believe that we have improperly handled your request, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, please contact the Department of Patient Relations at (718) 270-1111. *No one will retaliate or take action against you for filing a complaint.*

Sincerely,

_____ Department