

**TUSCOLA COUNTY HEALTH DEPARTMENT (TCHD)  
REQUEST FOR ATTACHMENT OF DOCUMENTATION TO  
FUTURE PROTECTED HEALTH INFORMATION (PHI) RELEASE**

Name of Individual: \_\_\_\_\_

Individual's Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Amendment Request: \_\_\_\_\_

Date of Amendment Denial: \_\_\_\_\_

I request that the TCHD provide a copy of my Request for Amendment and your Denial of Request with any future disclosure of the PHI that is subject to the Amendment Request.

\_\_\_\_\_  
Signature of Client/Legal Representative

\_\_\_\_\_  
Date