Tuscola County Health Department (TCHD)
Client's Statement of Disagreement with a Denial of Amendment of Protected Health Information

Individual's Name:_____

Birth date: _____

Social Security #: _____

Address:_____

Date amendment was requested: _____

Date amendment was denied: _____

Description of information in question:

Client statement of disagreement:

_____ _____

Signature of Patient or Legal Representative **Date:**

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Provider Rebuttal

For Tuscola County Health Department Use Only

Provider Rebuttal:

Name of provider: _____ **Title:** _____

Signature of provider: _____ **Date:** _____