LifeStance HEALTH

LIFESTANCE HEALTH, INC.
AMENDMENT OF PROTECTED HEALTH INFORMATION

Date Received: ___________________

SECTION A: Patient to complete the following information

Date: ___________________________

Patient Name: _______________________________ Medical Record Number___________________

Address: ____

REQUEST:

I hereby request that LifeStance Health, Inc. and/or its affiliates (collectively "LifeStance") amend the following in my Designated Record Set **(check all that apply)**:

_____ Medical Records _____ Billing Records

Date(s) of information to be amended (i.e., date of visit, treatment, or other health care services)

____

The information is incorrect or incomplete in the following manner:

____
____
____
____

I request this amendment for the following reason(s):

____
____
____
____

The information should be amended as follows:

____
____
____
____

Please help us identify persons who have received the Information (prior to Amendment/Correction):

Name	Organization/Address	Phone Number
________________	____	( ) ____________
________________	____	( ) ____________
________________	____	( ) ____________
________________	____	( ) ____________

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I understand that LifeStance may or may not supplement my record with an addendum based on my request. I also understand that LifeStance is not able to alter the original documentation in a record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information.

____ ___________________________

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representative’s Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

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<u>SECTION B</u>: [COVERED ENTITY] to complete the following

Date of Receipt of Request ______________________________________

Request for correction / amendment has been: _____ Accepted _____ Denied

If denied, check reason for denial:

The PHI was not created by LifeStance.
The PHI is not part of patient's Designated Record Set.
The PHI is not available to the patient for inspection as required by federal law (i.e., psychotherapy notes).
The PHI is accurate and complete per [insert name(s)] review of records on [insert date].

<u>NOTICE TO PATIENT/OTHERS</u>

Patient and/or others notified of determination via one or more of the following **(check all that apply)**:

Amendment Acceptance Letter sent to patient on __________________ (date).
Amendment Acceptance with Consent to Notify sent to patient on __________________ (date).
Notification of Amendment sent to identified persons pursuant to patient authorization on __________________ (date).

____ ___________________________
Signature of Privacy Officer Date

____
Print Name