



COOK COUNTY HEALTH

As a patient and/or health plan member, you have the right to request that Cook County Health (CCH) change or amend your protected health information in the records we maintain. CCH may or may not approve the request under certain circumstances.

For CCH to respond promptly and accurately to your Amendment Request, please complete this form in its entirety.

Last Name			First Name			Middle Name		
Birth Date	Month	Day	Year	Today's Date		Month	Day	Year
Address			City	State	Zip	Phone		
REQUESTED AMENDMENT								
Please describe in detail how you want records amended. Please use an additional page, if necessary.								
REASON FOR REQUESTED AMENDMENT								
Please specify the reason(s) for your request.								
DATES OF SERVICE FOR REQUESTED AMENDMENT								
Please specify a date or date range for your request.								
Signature of Individual				Date				
FOR PERSONAL REPRESENTATIVES OF THE INDIVIDUAL								
Name of Personal Representative					Relationship to Individual			
<i>I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.</i>								
Signature of Personal Representative					Date			
Please return this form to this address or email.					The Office of Corporate Compliance			
Or, call this number with questions:					1950 W. Polk Street, Suite 9217			
1-877-476-1873					Chicago, IL 60612			
					Compliance@CookCountyHHS.org			