

**UCR HEALTH  
STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE AMENDMENT  
REQUEST AND DENIAL WITH FUTURE DISCLOSURE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that UCR Health denied my request to change my protected health information. My request was dated: \_\_\_\_\_

**STATEMENT OF DISAGREEMENT**

I want to file this “*Statement of Disagreement.*” I disagree with the denial because:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that UCR Health may prepare a written rebuttal to my Statement of Disagreement. A “rebuttal” is a statement of why the hospital thinks my Statement of Disagreement is wrong. If the hospital prepares a written rebuttal, I will receive a copy.

**REQUEST TO INCLUDE AMENDMENT REQUEST AND DENIAL WITH FUTURE DISCLOSURES**

I do not want to file a “Statement of Disagreement” but I want UCR Health to include my amendment request and the denial along with all future disclosures of the information subject to my amendment request.

\_\_\_\_\_  
(Signature of Patient or Representative)

\_\_\_\_\_  
Date

If representative, state relationship to patient: \_\_\_\_\_

*When you have completed this form, please return it to:* **University of California  
Riverside Health Correspondence, Health Information Management Department, 900  
University Avenue, Riverside, California 92521.**