



PHI အတင်သွန်ညါ ဒုးဟ့ၣ်/ဒုးတဲၣ်တဖၣ် အတူၣ်ကတၢ် (Request to Correct or Amend PHI)

ယ RiverValley Consulting Services, Inc. ဒီး Affiliates အခီပညီတဖၣ်အပူၤ အိၣ်ဝဲအံၤ—
ပှၤအသုးပျူၤသုၣ်အဂီၢ်—ကျဲးမာရီအတင်သွန်ညါလၢ တၢ်က့ၤန့ၣ်/ပးပှၢ်တဖၣ် ဒီး
တၢ်ပှၤပူၤအတၢ်သါအတၢ်န့ၣ် တၢ်အိၣ်မူတဖၣ်အပူၤ မတိကျ/မပြီၤစီၤဘၣ်တဖၣ်
ဒုးဟ့ၣ်ဒီးဒုးတဲၣ်အိၣ်ဝဲလဲၣ်. တၢ်တောင်းက့ၤလံာ်အိၣ်ဒီးလၢတၢ်—မၤလီၤအိၣ်အပူၤအပှၤအံၤ—HIPAA
Privacy Office, RiverValley & Affiliates, P.O. Box 1637, Owensboro, KY 42302—
အအိၣ်ထီၣ်လၢတဘျီ.

တၢ်မ့ၢ်ကွၢ်တဖၣ် အိၣ်အကျဲ (60) နံၣ်အပူၤ ကွၢ်ဝဲလဲၣ်; မ့ၢ်အကလဲၣ်တဖၣ်အိၣ်ဒီး (30) နံၣ်လၢ မၤအဲၣ်ဒီး
အတၢ်တက့ၢ်ကွၢ်အက့ၢ်အဂီၢ်အါထီၣ်လၢ ပှၤအံၤအတင်သွန်ညါန့ၣ်လဲၣ်.

လံာ်ဇီၤအံၤအပူၤ အတၢ်အဲၣ်အတၢ်ကီ တအိၣ်ဘၣ်:

Consumer အမိ: _____ Date of Birth: _____

Parent or Legal Guardian: _____ Relationship/Status: _____

Address: _____

Phone number: _____

ဒုးတဲၣ်လၢအတၢ်အဲၣ်—အိၣ်မူတဖၣ်ဒီးနံၣ်—ဒီး လိာ်အကတၢ် (Facility) မ့တမ့ၢ် သိလၢ—ဒ်လဲၣ်:

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ဘဉ်ဃးအတၢ်လံာ်အံၤ မတိကျ/မပြီစီတၢ်တဖၣ် ဒ်လဲၣ်:

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အတၢ်အဲၣ်မ့ၢ်ဒ်လဲၣ်အိၣ်ဝဲလၢ ပှၤအံၤအတၢ်သ့ၣ်ညါ ပှၤတဖၣ်ဒီးမၤတၢ်ကွဲးတဲၢ်သ့ဝဲ—

ပှၤဒီးအိၣ်မူတဖၣ်အဂီၢ်ဒီးဒုးဟ့ၣ်ဒီးဒုးတဲၢ်—ဒ်လဲၣ် (အပူၤလၢပှၤမၤအဲၣ်ထီၣ် လံာ်ဇီၤအအိၣ်ထီၣ်):

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မှပုအံဒုးဟုဒီးဒုးတံအတၢ်သ့ၣ်ညါအံ၊ ပုအံမုဒုးလီဒီးပုတဖၣ်လၢ အိၣ်ဝဲလၢ
ဒုးဟုဒ်အံမုတၢ်ကိးဃီတဖၣ်အပူ—ဒုးဟုဒ်အီတဖၣ်. ပုအံအိၣ်တုလီ
ပုသ့တဖၣ်လၢအတၢ်လီထီၣ်မုလၢမတၢ်တၢ်ပူ—မၤအံအိၣ်ဒီး:

☐ အမုၢ်ဘၣ်. Initial: _____ ☐ မုၢ်. အပၢ်က့ၤအမိဒီးလိာ်အကတၢ်လၢအဘၣ်:

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အံလၢ ပုတဖၣ်လၢအိၣ်ဝဲလၢ ဒုးဟုဒ်မုတၢ်ကိးဃီတဖၣ်အပူ လၢအတၢ်ကိးကျိၣ်အဝဲသ့ၣ်—
န့မးအတၢ်ပူအဂီၢ်အါဝဲလၢ—ဒုးလီဒီး. လိာ်အီၤဒ်လဲၣ်:

☐ အမုၢ်ဘၣ်. Initial: _____ ☐ မုၢ်. Initial: _____



လံနု (Signature) – Consumer ဒီး/မုာ် တရားဝင် ကိုယ်စားလှယ်: _____

အမိ (Print Name): _____

နံၣ် (Date): _____

တရားဝင် ကိုယ်စားလှယ် အဆင့်/Relationship: _____

***** INTERNAL PURPOSES ONLY *****

Action/Comments to the Request for PHI Amendment:

Action must be taken within sixty (60) days of receipt of the request.

☐ Request accepted

☐ Request denied for the following reason*:

☐ Information was not created by this organization.

☐ The information is accurate and complete.

☐ Information is not part of your designated record set.

☐ Under the law, you are restricted from accessing or amending this information.

☐ RIVERVALLEY requests a 30-day extension to respond due to: _____

Comments from healthcare provider who provided services: _____



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Name of Staff Member Completing Form: _____ Title/Program/Location: _____

Signature of Healthcare Provider Who _____ Date: _____

Provided Service: _____

* If denied in whole or in part, you may submit a written statement of disagreement to: HIPAA Privacy Office, RiverValley & Affiliates, P.O. Box 1637, Owensboro, KY 42302. You may also file a complaint with our Office of Consumer Affairs (270-689-6500) or with the Secretary of the U.S. Department of Health & Human Services.