Patient Statement of Disagreement

Patient Name:_____ DOB: _____

Address:_____

City:_____ State:_____ ZIP: _____

Home Phone: (_____)_____ Work Phone: (_____) _____

Medical Record Number:_____ E-mail: _____

Statement of Disagreement:

_____

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Patient or Legal Representative Signature:_____

Relationship to Patient: _____ Date:_____ Time:_____

- You may request that Cameron Health provides your request for amendment and the denial with any future request for information.
- If you want more information about our privacy practices, have questions or concerns, or believe that we may have violated your privacy rights, please contact our Privacy Office in the Corporate Compliance Department in writing: Attn: Privacy Officer, Cameron Health 416 E. Maumee St., Angola, IN 46703 or by phone 260-667-5350 or toll free 833-703-5700.
- You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address upon request. We support your right to protect the privacy

Place Patient Label or

Patient Name_____

DOB_____

MRN_____