REQUEST FOR AMENDMENT OF HEALTH INFORMATION

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C., Chapter 55, Medical and Dental Care; 45 CFR 164, Security and Privacy; Department of Defense (*DoD*) Instruction 6015.23, Foreign Military Personnel Care and Uniform Business Offices in Military Treatment Facilities (*MTFS*); DoD Manual (*DoDM*) 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (*HIPAA*) Privacy Rule in DoD Health Care Programs;" and E.O. 9397 (*SSN*).

PURPOSE: The DHA Form 107 is used to document an individual's requests for amendment or removal of erroneously Personally Identifiable Information (*PII*) or Protected Health Information (*PHI*) information entered within the EHRs.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. § 552a(*b*) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies (including the Departments of Veterans Affairs, Health and Human Services, and Homeland Security for members of the Coast Guard) in connection with your medical care, government agencies to determine your eligibility for benefits and entitlements, government and nongovernment third parties to recover the cost of MHS provided care, public health authorities to document and review occupational and environmental exposure data, and government and nongovernment organizations to perform DoD-approved research. DoD's Routine Use disclosures are limited to those explicitly stated in each SORN. For a full listing of the Routine Uses, refer to below applicable SORNs hyperlinked below.

Any protected health information (*PHI*), including mental health and substance abuse information, in your records may be used and disclosed generally as permitted by the federal privacy protections for substance use disorder (*SUD*) treatment information, 42 USC § 290dd-2 and 42 CFR Part 2 (*collectively known as "Part 2"*) and HIPAA Rules (*45 CFR Parts 160 and 164*), as implemented within DoD by DoDM 6025.18. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: EDHA 07, Military Health Information System (*June 15, 2020; 85 FR 36190*)
https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but there may be an administrative delay in receiving care.

I. PATIENT INFORMATION

1. NAME *(Last, First, Middle Initial)*		2. DATE OF BIRTH *(YYYYMMDD)*	
3. ADDRESS	4. CITY	5. STATE	6. ZIP CODE

II. ENTRY INFORMATION

7. DATE OF ENTRY TO BE AMENDED *(YYYYMMDD)*	8. TYPE OF ENTRY *(check one)*
	☐ CLINICAL ☐ DEMOGRAPHIC

9. LOCATION OF ENTRY

☐ AHLTA ☐ CHCS ☐ ESSENTRIS®

☐ HAIMS ☐ MHS-GENESIS ☐ Other _____

10. ENTRY EXPLANATION

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate?

III. AMENDMENT INFORMATION

11. TO SEND THIS AMENDMENT OR NOT *(check one)*
Would you like this amendment sent to anyone to whom we may have disclosed the information in the past?

☐ YES ☐ NO

12. IF YES
Please specify the names and addresses of the organizations or individuals *(Use the back of the page for additional names and addresses)*

	a. NAME	b. COMPLETE ADDRESS
(1)		
(2)		
(3)		
(4)		

IV. PATIENT SIGNATURE

13. SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN	**14. DATE**

V. HEALTH CARE PROVIDER COMMENTS AND INFORMATION

15. COMMENTS OF THE HEALTH CARE PROVIDER

16. NAME *(Last, First, Middle Initial)*	**17. DEPARTMENT LOCATION**

18. TITLE	**19. SIGNATURE**	**20. DATE**

VI. DOCUMENT ACKNOWLEDGEMENT

21. DATE RECEIVED *(YYYYMMDD)*	**22. AMENDMENT HAS BEEN**	**23. IF DENIED, CHECK REASON FOR DENIAL**
	☐ ACCEPTED ☐ DENIED	☐ Information not created by the MTF ☐ Information not part of the Designated Record Set ☐ Information is accurate and complete ☐ Information not available for inspection ☐ Other _____

Please Note: If this request is denied in whole or in part, you may file a written statement of disagreement with the office staff who processed the initial amendment request. If you choose not to file a statement of disagreement, we will include your Request for Amendment/Correction of Health Information, as well as this denial of your request, with any future disclosures of the protected health information that is the subject of the requested amendment.