LIFESTANCE HEALTH, INC.
AMENDMENT OF PROTECTED HEALTH INFORMATION

Date Received: _____

SECTION A: Patient to complete the following information

Date: _____

Patient Name: _____ Medical Record Number_____

Address: _____

REQUEST:

I hereby request that LifeStance Health, Inc. and/or its affiliates (collectively "LifeStance") amend the following in my Designated Record Set **(check all that apply)**:

_____ Medical Records _____ Billing Records

Date(s) of information to be amended (i.e., date of visit, treatment, or other health care services)

_____

The information is incorrect or incomplete in the following manner:

_____

_____

_____

_____

I request this amendment for the following reason(s):

_____

_____

_____

_____

The information should be amended as follows:

_____

_____

_____

_____

Please help us identify persons who have received the Information (prior to Amendment/Correction):

Name	Organization/Address	Phone Number
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____

I understand that LifeStance may or may not supplement my record with an addendum based on my request. I also understand that LifeStance is not able to alter the original documentation in a record under any circumstances. Regardless whether my request is granted or denied, I understand that this request will be made a part of my permanent Medical Record and will be sent as part of the Medical Record in response to any authorized requests for release of my Protected Health Information.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

SECTION B: [COVERED ENTITY] to complete the following

Date of Receipt of Request _____

Request for correction / amendment has been: _____ Accepted _____ Denied

If denied, check reason for denial:

- ☐ The PHI was not created by LifeStance.
- ☐ The PHI is not part of patient's Designated Record Set.
- ☐ The PHI is not available to the patient for inspection as required by federal law (i.e., psychotherapy notes).
- ☐ The PHI is accurate and complete per [insert name(s)] review of records on [insert date].

NOTICE TO PATIENT/OTHERS

Patient and/or others notified of determination via one or more of the following **(check all that apply)**:

- ☐ *Amendment Acceptance Letter* sent to patient on _____ (date).
- ☐ *Amendment Acceptance with Consent to Notify* sent to patient on _____ (date).
- ☐ *Notification of Amendment* sent to identified persons pursuant to patient authorization on _____ (date).

_____ _____

Signature of Privacy Officer Date

_____

Print Name