University of Maryland, School of Dentistry

Acceptance of Amendment/Correction Request

*Medicaid ID# or Soc. Sec. #:*_____

_____ Date Filed: _____
Client Name Date Processed: _____

_____
_____
_____
Address

Dear (Client name):

Thank you for submitting your request for an amendment or correction of your health information.

☐ Your request has been accepted in full.
☐ Your request has been accepted in part.
☐ You will receive a separate letter about the area of your request that was denied.
☐ The appropriate amendment to your protected health information and/or record has been made to your record.

The amended information will be forwarded to the organizations or individuals you identified on your initial request. If you did not indicate that we forward the amended information, you may wish to do so by contacting:

Assistant Dean of Clinical Affairs,
Room 5209,
650 West Baltimore Street,
Baltimore, MD 21201

Sincerely,

_____
Name Job Title

c: Case File

Please direct questions related to HIPAA and privacy to:	**Please direct questions related to patient records to:**
Mr. Kent Buckingham, MS, HIPAA Officer University of Maryland School of Dentistry 650 West Baltimore St., Room G424, Baltimore, MD 21201 Kbuckingham@umaryland.edu (410)706-0343 (410)706-3389(fax)	Dr. Lou Depaola, DDS, MS, Associate Dean of Clinical Affairs University of Maryland School of Dentistry 650 West Baltimore St., Room 5209, Baltimore, MD 21201 Ldepaola@umaryland.edu (410)706-1189 (410)706-0519(fax)