UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

University of Maryland, School of Dentistry

Statement of Disagreement for Denial of Amendment or Correction of Health Information

Name:	Date:
Mailing Address:	Date of Birth:
City/State/Zip	Medicaid ID# or Soc. Sec. #:

I disagree with the decision to deny my request to amend my protected health information because: _____
_____
_____
_____
_____
_____

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

_____ _____
Signature of Witness (If signed with an "X" or mark) Date

Return this form to: _____

University of Maryland, School of Dentistry USE ONLY

Date received: _____

☐ Rebuttal ☐ No Rebuttal
Comments: _____
_____
_____

_____ _____
Signature & Title of Agency Representative Date

Please direct questions related to HIPAA and privacy 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)	Please direct questions related to patient records to: 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)