STATEMENT OF DISAGREEMENT WITH RESPONSE TO REQUEST TO AMEND OR CORRECT A RECORD

I, _____, disagree with [name of health plan]'s ("Health Plan") Response to my Request to Amend or Correct information contained in my Protected Health Information. A copy of my Request to Amend or Correct and the Health Plan's response are attached. I disagree as follows:

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Signature: _____Date: _____

Please mail or fax the completed Form to: Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax)**.**

(Attach additional sheets as necessary. Limited to 5 pages.)