[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Name of Privacy Officer or Records Manager]
[Name of Healthcare Facility/Provider]
[Address of Healthcare Facility/Provider]

RE: Formal Statement of Disagreement for Medical Records of [Your Full Name] (DOB: [Your Date of Birth])

Dear [Name of Privacy Officer or Recipient],

I am writing to formally submit a Statement of Disagreement regarding my medical records, as permitted under the HIPAA Privacy Rule (45 CFR $ 164.526).

On [Date of Original Request], I requested an amendment to my health information dated [Date of Entry to be Amended]. On [Date of Denial Letter], I received a notification that my request for amendment was denied.

I disagree with your decision and request that the enclosed Statement of Disagreement be permanently appended to my medical record. I also request that this statement be included with any future disclosures of the disputed portion of my record.

Statement of Disagreement:

[Provide a concise summary of the information you believe is incorrect and why. Keep this section brief, as many providers limit the length of the statement to one or two pages.]

Please confirm in writing that this statement has been added to my file. Thank you for your assistance in ensuring the accuracy of my medical documentation.

Sincerely,

[Your Signature]

[Your Printed Name]