STATE OF HAWAII
Department of Human Services

Med-QUEST Division

Request to Amend Confidential Information

I, (1) _____(if legal representative,
Print name of - Circle One: (Applicant, Recipient, Legal Representative)

(2) _____), **Signature**: _____
(Description of Legal Representative's Authority)

Request the Department of Human Services, Med-QUEST Division (MQD) to:

Identify the information you believe is inaccurate or incomplete: (3) _____

_____

_____

Amend the following specific information: (4) _____

_____

_____

The reason you wish to amend information maintained by MQD: (5) _____

_____

_____

Please note: Med-QUEST Division must notify you within 20 business days of a decision on your request to amend confidential information.

For MQD Use Only:

Date Received: ____/____/____ Amendment has been: ☐ Accepted

Reviewed by: _____ Date: ____/____/____ ☐ Accepted, unverified

Signature: _____ ☐ Denied

☐ The information is accurate and complete

☐ The information did not originate from or is created by MQD:

Comments of the originator: _____

_____

_____

_____ _____ ____/____/____
Name/Title of Originator Signature MM DD YYYY

Amendment forwarded to:

Name: _____ Date: ____/____/____ By: _____

Name: _____ Date: ____/____/____ By: _____

Name: _____ Date: ____/____/____ By: _____