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) _________________________

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Amend the following specific information: (4) ____

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

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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: ____/____/____

Reviewed by: __________________________ Date: ____/____/____

Signature: ____

Amendment has been:

☐ Accepted

☐ Accepted, unverified

☐ Denied

☐ The information is accurate and complete

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

Comments of the originator: ____

____

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

Amendment forwarded to:

Name: ____ Date: ____/____/____ By: __________

Name: ____ Date: ____/____/____ By: __________

Name: ____ Date: ____/____/____ By: __________