# REQUEST FOR AMENDMENT OF HEALTH INFORMATION

THE OREGON CLINIC

**PART A. INDIVIDUAL TO COMPLETE THE FOLLOWING INFORMATION (please print):**

Name (last, first, middle): _____

Address: _____

Telephone No.: _____ Date of Birth: _____

Medical Record No.: _____

**REQUEST:**

1. Description or a copy of the medical record that I want amended (include provider name, date(s) of service, and type of information such as lab test results, physician notes, etc.) (please attach supporting notes as necessary):

   _____

   _____

   _____

   _____

2. I request that the information be amended as follows (attach supporting document(s) as necessary):

   _____

   _____

   _____

   _____

3. Reason(s) for my request to amend:

   _____

   _____

   _____

   _____

4. If the amendment is accepted, I request that The Oregon Clinic (TOC) provide this amendment to the following person(s) who has/have received my health information in the past (please specify the name, address, and phone number of the individuals or organizations):

   _____

   _____

   _____

   _____

**I understand that accepted amendments will be added or linked to the original documentation and become part of the permanent health record.**

Date: _____

Signature of Patient/Legal Representative: _____

Printed name of Legal Representative: _____

**PART B. HIPAA SPECIALIST OR PRIVACY OFFICER TO COMPLETE THE FOLLOWING:**

Date of receipt of request: _____

Date the request is sent to TOC provider (include provider's name): _____

**Request for correction/amendment has been**: ☐accepted ☐denied

If denied, check reason for denial:

- ☐ the PHI was not created by TOC
- ☐ the PHI is not part of the individual's designated record set
- ☐ the PHI is accurate and complete
- ☐ no reason provided for amendment
- ☐ Request for Amendment not completed

Provider/Staff comments:

_____

_____

_____

_____

**Notice to Individual/Others**

Individual and/or others notified of determination via one or more of the following (check all that apply):

- ☐ Notice of Acceptance of Amendment sent to individual on: _____
- ☐ Notice of Denial of Amendment sent to individual on: _____
- ☐ Notice of Acceptance of Amendment sent to identified persons pursuant to individual's authorization on: _____

Date: _____

Signature of HIPAA Specialist/Privacy Officer: _____

Name and Title: _____