Salem Health Hospitals and Clinics

Request to Amend Protected Health Information

A patient or legally authorized representative who believes information in the patient's medical record is incomplete or incorrect may request an amendment to the record by completing the form below.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Phone #: _____ Medical Record # (*optional*): _____

Street: _____ City: _____ State/Zip: _____

Date of Record: _____ Name of person who wrote the information in the record: _____

Please include a copy of the medical record, if possible.

EXPLAIN HOW THE INFORMATION IN YOUR RECORD IS INCORRECT OR INCOMPLETE	EXPLAIN HOW THE INFORMATION SHOULD BE AMENDED TO BE MORE ACCURATE OR COMPLETE

IF AMENDMENT IS **APPROVED** PLEASE SEND COPIES TO

If you would like a copy of the amended record to be sent to your care provider, who has received the record in the past, please specify the name(s) and address(es) below:

Name:	Mailing Address:

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

Please return completed form to: Salem Health Privacy Officer
Corporate Integrity Office
P.O. Box 14001
Salem, OR 97309-5014

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