# 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 |
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### 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: |
|---|---|
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| | |

_____ _____

**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

DSC 436384 (9/16)