Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd.
Mail Code: OP17A
Portland, Or 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Stamp Patient Card Here

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

SECTION A: Individual to complete the following information. (Please print)

NAME ______________________________
Last First Middle

ADDRESS ______________________________

TELEPHONE NO. ______________ BIRTH DATE ______________

MEDICAL RECORD NO. ______________

REQUEST:

1. Description or a copy of the health information I want amended (include provider name, date(s) of service and type of information, i.e. lab test results, physician notes, etc.) (Please attach supporting documents as necessary.):______________________________
2. I request that the health information be amended as follows: (Include attachment(s) as necessary):
____
3. I request this amendment for the following reason(s): ______________________________
4. If the amendment is accepted, I would like this amendment to be provided to the following persons who have received my health information in the past **(please specify name, address, and phone number of the individuals or organizations):**
____

MR1449

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

Date: ______________

Signature of Patient or Legal Representative ______________________________

Printed Name of Legal Representative (If applicable) ______________________________

 - continued on reverse -

Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd.
Mail Code: OP17A
Portland, Or 97239-3098
(503) 494-8521, Fax (503) 494-6970
continued from page 1

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Stamp Patient Card Here

SECTION B: Please review the patient's amendment request and complete the following steps in Section B.

The request, amendment decision, and health information in questions shall be returned to the following OHSU location:

- ☐ Health Information Services
- ☐ Patient Business Services
- ☐ OHSU Medical Group

DATE OF RECEIPT OF REQUEST ______________________________

Request for correction / amendment has been: ☐ Accepted ☐ Denied

If denied, check reason for denial:

- ☐ The PHI was not created by OHSU.
- ☐ The PHI is not part of individual's designated record set.
- ☐ The PHI is accurate and complete.
- ☐ No reason provided for amendment.
- ☐ Request for Amendment not completed.

Provider/Staff Comments ____

Signature of Health Care Provider ____ **Date** _________________

Print Name ____

SECTION C: Health Information Services, Patient Business Services, or OHSU Medical Group to complete the following.

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 ______________.
  (date)
- ☐ Notice of Denial of Amendment sent to individual on ______________.
  (date)
- ☐ Notice of Acceptance of Amendment sent to identified persons pursuant to individual's authorization on ______________.
  (date)

Date _____________________

Signature of Staff Member ____

Print Name and Title ____