Salem Clinic
Belong. For life.

MEDICAL RECORDS AMENDMENT AND/OR CORRECTION REQUEST FORM

Instructions

This request form should be completed by the patient (or legal representative) in order to request a change to documentation located within the medical record. This form is not to be used to request a correction to how a service was billed; for those requests, please contact our billing office at 503-399-2424, option 5. Please return the completed form to Salem Clinic along with any supporting documentation you wish to provide.

Patient Demographics

Name: _____ Date of Birth: _____

Phone: _____ (day) _____ (evening)

Address: _____
(Street or PO Box)

_____
(City) (State) (Zip Code)

Amendment or Correction Request Details

1) Date of service of medical record entry to be corrected: _____

2) Current medical record language: _____

3) Requested amendment / correction to language: _____

4) Reason for the amendment / correction request: _____

Authorization to Provide Amended / Corrected Records

5) Please help us identify who has received the information (prior to Amendment/Correction):

Name Organization / Address Phone Number

6) Do you authorize us to provide the information in items 3 and 4 to the persons/organizations listed above in item 5?

☐ Yes ☐ No

Do not provide the information to: _____

Notices and Patient Signature

TO OUR PATIENTS: You have the right to submit a Medical Record Amendment/Correction Request Form to be made a part of your medical record. This right does not permit you to alter or change the original record created by your physician or his/her staff. We may deny your request to amend or correct your records.

_____ _____

Signature of Patient Date

If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this documentation with any future disclosures of the informatiuon identified in Items no.1 and no. 2 above. Please make your request in writing, and sign and date the request.

If you believe we have failed to meet out obligations as explained in our "Notice Of Primacy Practices" or our legal obligations under state or federal law, you may contact our Privacy Office regarding your complaint, and you may file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.

For Salem Clinic Office Use Only

Date Received: _____ MRN: _____

CCID: _____

☐ Amendment / Correction Request **Approved**

☐ Amendment / Correction Request **Denied**

Reason for denial: _____

_____

Outcome Communicated to the Patient: _____

Date Method Staff Member

This Amendment/Correction request form is to be made a permanent part of the Medical Record