HIPAA REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

INDIVIDUAL'S NAME *LAST:*	*FIRST:*	*MIDDLE:*
HOME ADDRESS:		
HOME PHONE:	DATE OF BIRTH (MM/DD/YYYY):	

I hereby request that St Charles Health System (SCHS) amend **[please check all boxes that apply]**:

- ❑ My medical records.
- ❑ My billing records
- ❑ My records used by or for SCHS to make decisions about me
- ❑ All of the above as specifically described below.

I understand that SCHS may deny this request as permitted under Federal law and that I will be informed by SCHS concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with such denial. I further understand that SCHS will notify me as of its decision to accept or deny my request within 60 days of receiving this request. If SCHS is unable to comply with my request within this timeframe, I understand that SCHS may extend the applicable deadline for up to an additional 30 days by notifying me in writing.

1. Describe the information you want amended (e.g., procedures, nursing/physician notes, test results):

   _____

   _____

   _____

   Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care services):

   _____

2. What is your reason for making this request?

   _____

   _____

   _____

3. How is the entry incorrect or incomplete?

_____

_____

_____

4. What should the entry say to be more accurate or complete? (Please be as specific as possible.)

_____

_____

_____

5. Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, health plan, or other health care provider)? ❑ Yes ❑ No

   If yes, please specify the name(s) and address(es) of such organization(s) or individual(s):

_____

_____

_____

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative Relationship to Patient

After you have completed this form, please return it to the Privacy Officer by mail or by fax at the following address:

Privacy Officer
St Charles Health System
2500 NE Neff Rd.
Bend, OR 97701
(541) 706-7760
(541) 706-4778 FAX
email: privacyofficer@stcharleshealthcare.org