

# 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:	<input type="text"/>	Date of Birth:	<input type="text"/>
Phone #:	<input type="text"/>	Medical Record # (optional):	<input type="text"/>
Street:	<input type="text"/>	City:	<input type="text"/>
		State/Zip:	<input type="text"/>
Date of Record:	<input type="text"/>	Name of person who wrote the information in the record:	<input type="text"/>

*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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

### 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:
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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