



OREGON MEDICAL GROUP

MEDICAL RECORD AMENDMENT/CORRECTION FORM

Patient Name: _____ Phone Number: _____ (Home)

Date of Birth: _____ (Other)

Patient Address: _____
(Street or PO Box)

(City) (State) (Zip)

1. Date of Medical Record Entry to be Corrected _____

2. Medical Record Language to be Amended/Corrected: _____

3. Amendment/Correction: _____

4. Reason for the Amendment/Correction: _____

5. Please help us identify persons who have received the Information (prior to Amendment/Correction):

Name Organization/Address Phone Number

() _____

() _____

6. Do you authorize us to provide the information in Items no. 3 and no. 4 to the persons/organizations listed in Item no. 5?

Yes

No Do not provide the information to: _____

TO OUR PATIENTS: You have the right to submit a Medical Record Amendment/Correction Sheet 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.

Amendment/Correction **Accepted**

Amendment/Correction **Denied**

Reason for Denial: _____

Physician Signature: _____ Date: _____

(Patient Name)

(Date)

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 document with any future disclosures of the information 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 our obligations as explained in our "Notice Of Privacy Practices" or our legal obligations under state or federal law, you may contact the Privacy Officer at 541-242-4390 or at our offices located at 1580 Valley River Drive, Suite 100, Eugene, OR 97401 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.

Completed form may be returned to PO Box 1648 Eugene, OR 97440