LEGACY HEALTH

LEGACY HEALTH

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

LAST NAME	FIRST NAME	MI	MEDICAL RECORD NUMBER
STREET ADDRESS			DATE OF BIRTH

CITY	STATE	ZIP CODE	HOME PHONE	WORK PHONE

I hereby request that Legacy Health (LH) amend [please check all boxes that apply]:

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

I understand that LH may deny this request as permitted under Federal law and that I will be informed by LH concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with such denial. I further understand that LH will notify me as of its decision to accept or deny my request within 60 days of receiving this request. If LH is unable to comply with my request within this timeframe, I understand that LH 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 legal representative / Date

After you have completed this form, please return it to the following address:

HIM Amendment Office – Legacy Health
1015 NW 22nd Ave – Wilcox Room 200
Portland, Oregon 97210
(503) 415-5138 Fax
(503) 413-6798 Phone