Women's Care
OBSTETRICS, GYNECOLOGY & MIDWIFERY CENTER

Patient		
Preferred Name/Maiden Name/Other		
Date of Birth (MM/DD/YYYY)	Phone number	
Street Address or PO Box		
City	State	Zip Code

MEDICAL RECORD AMENDMENT/CORRECTION FORM

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 release the information the amended record to the persons/organizations listed in Item no. 5?
   o Yes o 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.

o Amendment/Correction **Accepted** o Amendment/Correction **Denied**

Reason for Denial _____

This Amendment/Correction Sheet Is to Be Made a Part of the Medical Record of:

_____ _____
(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 Compliance Officer of our office, *Women's Care HIPAA Compliance Officer, P.O. Box 70368 Springfield Oregon 97475,* 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.

Please submit the completed to Women's Care's front desk or mail to the Women's Care Compliance officer.