The Portland Clinic MEDICAL RECORD AMENDMENT CHART CORRECTION FORM

Patient Name: _____MRN#: _____ Phone #: _____

Patient Address: _____ City: _____ State: ___ Zip Code: _____

A. Date of Medical Record Entry to be Corrected: _____
B. Medical Record Language to be Amended/Corrected:
_____
C. Amendment/Correction:_____
_____
D. Reason for the Amendment/Correction: _____
E. Please help us identify persons who have received the Information, prior to Amendment or Correction.

	Organization Name	**Address**	**Phone #**
1.			
2.			
3.			
4.			

Do you authorize us to provide the information in item C and item D, to the organizations in item E?

◯ **Yes**
◯ **No** Do not provide the information to: _____

TO OUR PATIENTS: You have the right to submit a Medical Record Amendment Chart Correction Form to be made part of your medical record. This right does not permit you to alter or change the original record created by your physician or their staff. We may deny your request to amend or correct your records.

Signature of Patient: _____ **Date:** _____

Return completed form to: **Mail:** The Portland Clinic LLP
Attn: Medical Records Department/HIM
15950 SW Millikan Way
Beaverton, OR 97003

Email: tpcdocfax@tpcllp.com

To be completed by Provider: (circle one)

☐ *Amendment/Correction: **ACCEPTED** ☐ * Amendment/Correction: **DENIED**

Reason for Denial, if applicable: _____

Signature of Provider: _____ **Date:** _____

This Amendment or Chart Correction Form Is to Be Made a Part of the Medical Record of:

Patient Name: _____

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 the 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 or chart 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 A and B 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 at our office regarding your complaint at **(503) 221-0161** or you may file a complaint with the Secretary of the U.S. Department of Health and Human Services at 1(877) 696-6775, 200 Independence Avenue, S.W. Washington, DC 20201, within 180 days of the date you know or should know of the act that is the subject of your complaint.