MID-COLUMBIA MEDICAL CENTER
The Dalles, Oregon

RECORD AMENDMENT

A patient has the right to request an amendment to the medical records maintained by Mid-Columbia Medical Center. The request shall be submitted by completing the patient portion of this form and delivering it to the Health Information Department. The responsible clinician will be notified to review the request and record, and to respond within 30 days. The patient will be notified by receiving a completed copy of this form within 60 days of the hospital's receipt of this request. If approved, the amended information will be entered into the record, a copy of this form will be sent to the patient and other persons the patient believes may have received the original information. If denied, the patient has the right to file a written statement of disagreement with the denial, and the right to have the request for amendment, the denial and, if submitted, the patient's written statement of disagreement attached to all future disclosures of the protected health information. The patient is entitled to a copy of the request.

RECORD AMENDMENT REQUEST

(To be completed by the patient.)

Patient Name: _____ Date of Birth_____

Date of entry to be amended: _____ Type of entry to be amended:_____

Explanation of inaccuracy: _____

_____

How should entry be amended to make it accurate: _____

_____

List the name and address of each person who you want us to notify of the amendment should it be approved: (Appropriate authorization for release of protected health information must be completed for each person.)

_____

_____

_____

Date of Request:_____ Signature of Patient: _____

RESPONSE TO REQUEST

(To be completed by MCMC Staff and Clinician.)

Date this request was received:_____ MR #: _____

____ Request Accepted.

____ Request Denied.

Reason for denial is: ____Is correct and complete. ____Was not created by this healthcare organization. ____ Is not part of the healthcare record. ____Is not allowed to be disclosed.

Comments:_____

_____

_____

_____/_____ _____/_____

Signature of Responsible Clinician / Date Signature of Health Information Staff / Date

If change is accepted, document the date of the notification to each person that the patient wants to have notified. Include completed form in the individual's records.