Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Complete and return this form to the above address to the attention HEALTH INFORMATION

Date of Request	Patient's Name (First Middle Initial and Last)
Date of Birth	Mailing Address
Phone Number	
Date Entry to be Corrected/Amended	Information to be corrected/Amended

Explain how the entry is incorrect or incomplete. What should the entry say to be accurate or complete? Use additional sheets if needed and attach to this form.

Check box(es) and Initial below:

☐ I agree to allow SCHC to make reasonable effort to provide the amendment to other persons who SCHC knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that will be detrimental to your health care. _____

☐ I would like this amendment sent to the following organization or individual and fax number:

_____ _____

Print name, sign and date. If your signature is your mark or thumbprint then your Representative or Witness will need to sign and state their relationship to you.

Print Patient's Name (First, Middle Initial and Last)	Date Signed
Signature of Patient	Mark or Thumb Print
Signature of Personal Representative or Witness	Relationship

SCHC HEALTH INFORMATION USE ONLY:

MRN	Date Received	Date Sent	Scanned

Process:

1. Print legible in all fields using dark permanent ink.
2. Sign and date the request.
3. Submit the complete and signed form to SCHC Health Information Staff.
4. You will receive a receipt letter within 10-business days from the date received by SCHC Health Information Staff.
5. SCHC Health Information Staff will notify you of the acceptance or denial of your request.
6. If request is accepted, with your permission, will release any amended information who rile or likely to rely on information or to an organization or individual you request the amended information to be sent.
7. This form and subsequent information pertaining to this request will become part of your permanent health record.

If you have any concerns or questions, you may contact the Health Information Staff as follows:

Health Information Supervisor (541)444-9619
Health Information & Privacy Officer (541)444-9635

FOR SCHC USE ONLY

REQUEST FOR CORRECTION/AMENDMENT HAS BEEN

☐Accepted ☐Denied Reason for Denial

☐PHI is not part of patient's designated record set

☐Record is not available to the patient for inspection under Federal law

☐SCHC did not create record

☐Record is accurate and complete

COMMENTS OF HEALTHCARE PROVIDER (if applicable)		
Signature of Healthcare Provider	*Title*	*Date*
Signature of SCHC Health Director or Designee		*Date*

SCHC HEALTH INFORMATION USE ONLY:

MRN	Date Received	Date Sent	Scanned