Request for Amendment of Health Information

As a participant in Outside In's services you have the right to request amendments to your personal health information that are inaccurate or incomplete. If you want to amend your health information, you must complete this form and return it to Outside In, ATTN: Privacy Officer, 1132 SW 13th Ave. Portland, OR 97205

If we deny your request, we will let you know in writing with an explanation of why we are denying it. You have the right to submit a written disagreement to our denial. We will put your statement and requested amendment in to your record. If we continue to disagree with your amendment request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

INDIVIDUAL'S INFORMATION		
Name:	Medical Record # or ID#:	
Birthdate:	Contact Phone Number:	Request Date:
Current Address (No., street, city, state, zip):		

REQUESTED AMENDMENT

1. Date(s) of Entry to be amended/corrected: _____

2. Type(s) of Entry to be amended/corrected: _____

3. Please explain how the entry(s) is incorrect or incomplete:

4. What should the entry(s) say in order to be accurate or complete:

5. Would you like this amendment sent to anyone to whom we may have disclosed information to in the past? ☐NO ☐YES
If so, please specify the name and address of the organization or individual:

ACKNOWLEDGEMENT
Please sign and date:

Patient/Client's Name (Print): Signature: Date:

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof or your relationship to the participant (e.g. Power of Attorney, legal guardian)

Signed By (Print): Signature: Date:

☐ **Parent of Minor Child** ☐ **Legal Guardian** ☐ **Power of Attorney** ☐ **Executor** ☐ **Other** _____