



REQUEST TO CORRECT OR AMEND PROTECTED HEALTH INFORMATION

Please fax or mail your completed form to:

Fax: (360) 449-1146

Mail: Rebound, Attn: Medical Records, 200 NE Mother Joseph Place, Suite 210, Vancouver, WA 98664

Patient name: _____ Date of birth: _____

Previous name: _____

Current mailing address: _____

I request to change my records

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record:** _____

Patient's or legally authorized individual's signature: _____ Date: _____

Relationship to patient if signed on patient's behalf (parent, legal guardian, personal representative): _____

We will review your request and respond within ten (10) days of receiving your request. A copy of your request will be added to your record. If we grant your request, we will send changes to anyone you identify and to anyone who received the information in the past and who needs to know about the change.

To be completed by the practice/health care facility:

Date received: _____ Correction/Amendment has been: accepted denied

The review of this request for correction/amendment has been delayed. Your request will be processed by the following date: _____ (not later than 21 days after the request).

If denied, check reason for denial:

- The existing health information is accurate and complete.
- This request does not pertain to the patient's medical and financial records.
- Due to federal and state laws, this health information is not available and therefore cannot be amended or corrected.
- This health information was not created by this organization.
- The record no longer exists or cannot be found.
- The record is not maintained by this organization.

Name of reviewing department or position: _____ Date: _____