Women's Healthcare Associates LLC

Request for Amendment of Protected Health Information

Last Name	First Name	MI	Medical Record Number
Street Address			Date of Birth
City	State	Zip Code	Phone

I hereby request that Women's Healthcare Associates (WHA) amend (please check all that apply):

☐ Medical Records ☐ Billing Records

I understand that WHA may deny this amendment request as permitted under Federal law and that I will be informed by WHA concerning the basis for the denial along with instructions concerning my right to submit a statement disagreeing with such denial. I understand that WHA may reasonably limit the length of my statement of disagreement and prepare a rebuttal to my written statement of disagreement (and provide me with a copy). I further understand that WHA will notify me of its decision to accept or deny my request within 30 days of receiving this request. If WHA is unable to comply with my request within this timeframe, I understand that WHA may extend the applicable deadline for up to an additional 30 days by notifying me in writing.

1. Describe the information you want amended (e.g. procedures, notes, tests, medical history, diagnosis):
   _____
   _____
   _____

2. Date(s) of Medical Record Entry to be Corrected: _____

3. Reason for the Amendment request:
   _____
   _____
   _____

4. What do you believe the entry should say to be more accurate or complete?
   _____
   _____

5. Please help us identify persons who have received or relied on the information in question (such as other healthcare providers, pharmacists, or health plans), if any:

Name	Organization/Address	Phone Number
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____

Patient / Legal Representative Signature:_____ Date:_____

After you have completed this form, please return it to:

Women's Healthcare Associates, Attn: Privacy Officer
7650 SW Beveland St, Suite 200
Portland, OR 97223
(503) 601-3615 Phone
(503) 646-1683 Fax

If WHA has denied your requested amendment/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 no. 1 and no. 2 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 Privacy Officer of our office regarding your complaint, and you may file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.