

FRONT

OWYHEE COMMUNITY HEALTH FACILITY REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

PATIENT NAME		DATE OF BIRTH	HEALTH RECORD NUMBER
PATIENT ADDRESS	CITY	STATE	ZIP CODE
DATE OF ENTRY TO BE CORRECTED/AMENDED	INFORMATION TO BE CORRECTED/AMENDED		

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

In the event that OCHF grants your request, in some situations where OCHF previously disclosed the disputed record, OCHF is required by law to notify the recipient of the corrective action taken. In addition, subject to your agreement OCHF will make reasonable efforts to provide the amendment to other persons who OCHF knows received the information in the past and who may have relied, or are likely to rely, on such information to your detriment.

I agree to allow OCHF to release any amended information to individuals or entities as described above.

Would you like this amendment sent to anyone else who received the information in the past?

Yes No If yes, please specify the name and address of the organization(s) or individual(s) below.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE <small>(If Legal Representative, state relationship to patient)</small>	DATE
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BELOW IS FOR OCHF USE ONLY

DATE RECEIVED	AMENDMENT HAS BEEN	IF DENIED, CHECK REASON FOR DENIAL
	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied	<input type="checkbox"/> PHI is not part of patient's record <input type="checkbox"/> OCHF did not create the record <input type="checkbox"/> Record is not available to the patient for inspection under Federal law <input type="checkbox"/> Record is accurate and complete

SIGNATURE OF HEALTHCARE PROVIDER (If applicable)	TITLE	DATE
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COMMENTS OF HEALTHCARE PROVIDER (If applicable)

SIGNATURE OF TRIBAL HEALTH ADMINISTRATOR (THA) OR DESIGNEE	DATE
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Instructions for Completing Form for Request For Correction/Amendment of Protected Health Information

1. Print legibly in all fields using dark permanent ink.
2. Sign and date the request.
3. Submit the completed and signed form to the THA or designee.
4. You will receive a photocopy of your completed form, as an acknowledgement of receipt of your request, no later than 10 business days after OCHF receives your request.
5. You will be notified of the acceptance or denial of your request.
6. If you agree to allow OCHF to release any amended information and if your request to amend is accepted:
 - a. OCHF will make reasonable efforts to send any amended or corrected information to anyone who OCHF knows received this information in the past and who may have relied, or is likely to rely, on such information to your detriment.
 - b. OCHF will make reasonable efforts to send the correction or amendment to those individuals or entities/organizations you identify and who have a need for the correction or amendment.
7. If your request is denied, you may do the following:
 - a. Submit to the THA a one-page written statement disagreeing with the denial and the basis of such disagreement within 30 days of the denial. The OCHF has the right to prepare a written rebuttal to any statement of disagreement. You will be provided a copy of any rebuttal statement.
 - b. If you submit a written statement of disagreement, the OCHF will include such statement or an accurate summary thereof with any subsequent disclosure of the health information to which the disagreement relates.
 - c. If you do not submit a written statement of disagreement, you may request in writing that the OCHF provide this request for correction or amendment (or summary) and the denial with any future disclosures.
8. If you have a complaint about OCHF's policies and procedures regarding health information, you may file such a complaint with the Tribal Health Administrator or with the Secretary, Department of Health and Human Services, Washington, DC 20201.
9. This form and subsequent information pertaining to this request will become part of your permanent health record.

Owyhee Community Health Facility
Tribal Health Administrator
1623 Hospital Loop
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