



MEDICAL RECORD AMENDMENT REQUEST FORM

I, _____, request to amend my personal health information maintained by Community Health Association of Spokane concerning treatment and services I received on the following date(s): _____

Reason for request: _____

I request that the information be amended as follows: (attach additional paperwork as needed) _____

Patient Name: _____

DOB: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

I have a right to request, in writing, that CHAS amend my information.

CHAS may deny my request if the information or record:

- Was not created by CHAS, unless you have a reasonable basis to believe that the original creator of the information is no longer available.
- Is considered accurate and complete by your CHAS provider;
- Includes psychotherapy notes;
- Is to be compiled in reasonable anticipation of, or for use in, a judicial proceeding;
- Is otherwise not available for your inspection under HIPAA;

CHAS must inform me whether the request has been accepted or denied within 10 days (or more in unusual circumstances) of receiving the request.

If I receive a denial, I have the right to add a statement of disagreement to my record.

Patient's Signature

Date

Legally Responsible Party Signature (if applicable)

Relationship to Patient

Date

Please return to the front desk staff or send to us by mail or email at the address's below:

Mailing Address: 611 N. Iron Bridge Way Spokane, WA 99202 or

Email to: Records@chas.org

Phone: 509.444.8888

Fax: 509.434.0392