

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Protected Health Information includes medications, health conditions, etc.

Please do not use this form to update your address or phone number.

You can fill out an address change request form online. Go to members.kp.org

Patient Name: _____

Health Record Number: _____

Patient Address: _____

Phone #: (Home) _____ (Work) _____

DOB: _____

I have received my protected health information. I believe that some of this information is not correct. I would like changes made for the following service dates and for the following reasons.

Please correct or add the following information to my health information for the dates listed above. (For some changes, such as immunizations, documentation or other proof may be required.)

(Use reverse side if needed.)

Signature of Patient or Legal Representative Date

Note: Verification of Authority to make request may be required

I understand that Kaiser Permanente may or may not add this addendum to my protected health information based on my request and under no circumstances is able to alter the original documentation of the protected health information. Nevertheless, this request for an addendum will be made part of my permanent protected health information and will be sent as part of my designated record set in response to any authorized requests for my medical information. Please send this form to:

**Kaiser Permanente
Release of Information
10220 SE Sunnyside Road
Clackamas, OR 97015**

You may also fax this form to: (503) 571-2624