Patient Rights Form: HIPAA Compliance

THE OREGON CLINIC

Please send this form to The Oregon Clinic Medical Records Department (ATTN: Clinical Content Manager) by:
FAX: (503) 935-8404 or **E-MAIL*:** compliance@orclinic.com or
MAIL: 847 NE 19th Avenue, Suite 300, Portland, OR 97232

*Communications via e-mail are not secure.

I, _____ (name)

__/__/__ (date of birth), on this date, __/__/__ (today's date), request the following:

1. Restrictions to my PHI. Please restrict the following:

2. Amendment(s) to my PHI. Please make the following amendments to my PHI:

3. I request an accounting of disclosures of my PHI.

Patient signature: _____ **Date:** __/__/__

FOR OFFICE USE ONLY

Submitted to Privacy Officer on: __/__/__ Received by Privacy Officer: __/__/__

Communication with patient & date: