

**Request to Amend a Record**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell  Work  Home Message Okay?  Yes  No

Please tell us what information in the record that you believe is inaccurate or incomplete. Please be as specific as possible. What should the record say to be more complete or accurate?

Date(s) of entry to amend: \_\_\_\_\_

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Signature of Client or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

If Parent/Guardian, print name: \_\_\_\_\_

Parent  Guardian  Other \_\_\_\_\_

You can file this Request one of three ways:

1. Give the completed form to your therapist or the front desk at the clinic where you receive services
2. Mail the completed form to WPCS C/O Joe Hromco PO Box 82819 Portland, OR 97282
3. Call Joe Hromco, Vice President of Operations at 503.828.8718

**For Office Use**

Received: \_\_\_\_\_ Decision date: \_\_\_\_\_

Accepted

Denied \_\_\_ PHI was not created by this organization \_\_\_ PHI is accurate and complete

\_\_\_ Other reason: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_