Request for Amendment of Medical Record

Patient Name	Date of Birth	Medical Record Number, if known
Address, City, State & Zip		
Telephone # ( )	Last 4 digits of SSN (Optional):	

Complete the following only if the person making the request is NOT the patient

Name of Requestor	Legal Authority: ☐ Parent ☐ Legal Guardian ☐ Other:

Amendment Information: *Complete all areas below with as much detail as possible. Attach additional information as necessary to describe the event(s).*

Date(s) of entry/entries to be amended (e.g. date of office visit, admission).	
Describe entry you want amended.	
Describe how the entry is incorrect or incomplete.	
How should the entry be amended to be more accurate?	
If amendment is accepted, do we have your permission to share amendment with individuals who received this information? Circle one: **Yes No.** If yes, please provide name(s) and address(s) of the organization(s) or individual(s) below.	

Signature of patient / patient representative _____ **Date** _____

Please send this completed form to:
HIM Department at 655 West 8th Street; Jacksonville, FL 32209 **or via fax** to 904-244-3165. **Keep a copy for your records.**

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Amendment was:	☐ Accepted as-is ☐ Accepted in part	☐ Denied *and* Reason for denial:	☐ PHI is accurate and complete ☐ PHI not created by Shands ☐ PHI not part of designated record set ☐ PHI is not available for inspection

Health Care Reviewer Comments: _____

Signature of Health Care Reviewer: _____ **Date** _____

☐ Patient has **not** filed a Statement of Disagreement, but requests future releases include the requested amendment and denial information.
☐ Patient filed a Statement of Disagreement, must be released along with other documentation with future releases of information.
☐ Facility / Provider appended written response / rebuttal and forwarded to patient.
☐ Facility / Provider did not provide a response / rebuttal.

Signature of HIM Representative _____ **Date** _____

Request for Amendment to Medical Record (A-05-009)

UFHealth JACKSONVILLE

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Approved: 08/27/12
Revised: 09/13/16

Distribution: Original to patient record, copy to requestor