

# 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: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other:
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**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: <b>Yes</b> <b>No</b> . 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.**

## FOR UF HEALTH JACKSONVILLE USE ONLY

Amendment was:	<input type="checkbox"/> Accepted as-is	<input type="checkbox"/> Denied <i>and</i> Reason for denial:	<input type="checkbox"/> PHI is accurate and complete
	<input type="checkbox"/> Accepted in part		<input type="checkbox"/> PHI not created by Shands <input type="checkbox"/> PHI not part of designated record set <input type="checkbox"/> 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)



Form # 190009  
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Approved: 08/27/12  
Revised: 09/13/16

Distribution: Original to patient record, copy to requestor