Florida Pediatric Associates

REQUEST FOR AN AMENDMENT TO PROTECTED HEALTH INFORMATION

Date: _____
Patient's name: _____DOB: _____
Patient medical record #_____
Patient Address: _____
_____
Phone Number: (Home) _____ (Work) _____
(Cell) _____

Describe the information you want amended (e.g., lab test results, physician notes):

_____

_____

Date(s) of information to be amended (e.g., date of office visit, treatment, or other health care service):

_____

_____

What is your reason for making this request?

_____

_____

What would you like to add/ change in the record?

_____

_____

_____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist, or other health care provider?) _____Yes _____No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s).

_____

_____

Signature: _____

Print Name: _____

Date: _____

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For Internal Use Only

Amendment has been: _____Accepted _____Denied
If denied, check the reason for denial:
_____ Health information was not created by this organization
_____ Health Information is not part of the patient's designated record set
_____ Health Information is accurate and complete

Staff comments:
_____

_____

Privacy Officer must review all denials

Denial letter sent to individual: _____
Signature of staff person: _____
Date: _____
Print Name and Title:
_____