TALLAHASSEE MEMORIAL HEALTHCARE
REQUEST FOR AMENDMENT/CORRECTION OF HEALTH INFORMATION

Patient Name:		Request Date:	
Street Address:		Birth Date:	
City/State/Zip:		MR/Account #:	
Home Number:		Cell Number:	

WHAT NEEDS TO BE AMENDED/CORRECTED & WHY

Entry to be Amended:	
Date & Author of Entry:	

Please Explain How the Information is Incorrect or Incomplete. What Should the Information State to be More Accurate or Complete? Additional documentation may be attached if needed.
(If available, please provide copy of pertinent record.)

Would You Like This Amendment Sent to Anyone to Whom We May Have Disclosed This Information in the Past? If So, Please Specify the Name and Address of the Organization or Individual (Name & Address):

I understand that the provider may or may not supplement the medical record with an addendum based on my request, and under no circumstances, is the provider able to alter the original medical record. In any event, this request for an addendum will be made part of my permanent medical record.

Signature of Patient/Legal Representative ______________________ Date ______________

FOR TMH INTERNAL USE ONLY

Decision Date:	❑ **Accepted**	❑ **Denied**

If Denied, Check Reason for Denial:

- ❑ PHI was not created by this organization
- ❑ PHI is not available to the patient for inspection as required by Federal law (e.g., psychotherapy notes)
- ❑ PHI is not part of patient's designated record set
- ❑ PHI is accurate and complete

Signature/Title of Staff Member:
Print Name:
Comments:

❑ Individual was informed of denial in writing (attach letter of communication)

Signature/Title of Staff Member ______________________ Date ______________

❑ Individual has requested amendment/denial be included with any future disclosures of PHI *(must be requested in writing and attached to this document)*

Signature/Title of Staff Member ______________________ Date ______________