HALIFAX HEALTH
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

Health Information Management · Halifax Health · 303 N. Clyde Morris Blvd., Daytona Beach, FL 32114

Patient – please fill in the following information:

1. Patient Name (print):_____
2. Patient Address: _____
3. Date of Birth:_____ Social Security #: _____
4. Describe the information you want amended (i.e., lab tests, results, physician note, etc.):_____

   _____
5. Date of Service (hospitalization, clinic visit, E.R., etc.): _____
6. Reason for making this request:_____
7. Do you know of anyone who may have received or replied on the information in question (such as your doctor, health plan, etc.)? ☐ Yes ☐ No If yes, please specify the name(s) and address(es) of the individual(s) or organization(s):

   _____

   _____

   _____

I understand the physician / practitioner may or may not supplement the medical record with a correction / addendum based on my request, and under no circumstances, will anyone be able to alter the original documentation of the medical record. In any event, this request for a correction / addendum will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests for my medical information.

I request the following correction / supplement be made on my Medical Record: _____

_____

_____

_____

_____

_____

_____

SIGNATURE (Patient or Legal Representative) Date

For Healthcare Organization Use Only – RESPONSE

Medical Record Number: _____

☐ ***Accepted:*** In response to your request, a correction/addendum shall be made part of your permanent medical record.

☐ ***Not Accepted:*** Your request has been made a part of your permanent medical record; however, your request has been denied for the following reasons:

Please check the reason for denial (PHI = personal health information)

- ☐ PHI was not created by this organization.
- ☐ PHI is not part of the patient's designated record set.
- ☐ Federal law forbids making the PHI in question available to the patient for inspection (psychiatric, abuse, etc.)
- ☐ PHI is accurate and complete as it stands.
- ☐ Other: _____

Physician / Practitioner Queried:_____

Staff Person's Signature: _____ Date:_____ Dept.:_____