

PATIENT REQUEST FOR MEDICAL RECORD/PHI AMENDMENT

Patient Name: _____ Patient Date of Birth: _____

Patient Address:

Medical Record Number: _____ Date of Entry to be Amended: _____

Explain how the information entered on your health record is incorrect or incomplete. Include what the information should say to be more accurate or complete.

Do you need this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please indicate the name and address of the individual or organization.

Name and Address:

Signature of Patient or Personal Representative Date

Printed Name of Personal Representative Relationship to Patient

For H. Lee Moffitt Cancer Center & Research Institute Hospital's Use Only:

Date Amendment Request Received: _____ Amendment Status: ____ Accepted ____ Denied

If the Amendment Request is denied, check reason for denial:

- The Protected Health Information (PHI) was not created by this organization
- The Protected Health Information is not available to the patient for inspection as required by law (e.g., psychotherapy notes).
- The Protected Health Information is not part of the patient's medical record
- The Protected Health Information is accurate and complete

Name of Staff Member: _____ Title: _____

Comments of Healthcare Practitioner:

Signature of Healthcare Practitioner Date



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