

**JACKSON HEALTH SYSTEM  
REQUEST FOR AMENDMENT/CORRECTION OF  
PROTECTED HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_ JHS Medical Record # \_\_\_\_\_

Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_  
(optional)

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Treatment Date(s): \_\_\_\_\_

Type of Entry to be Amended: \_\_\_\_\_

Date of Entry to be Amended: \_\_\_\_\_

Please explain how the information is incomplete or incorrect.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the information that you feel should be included in order to make the record more accurate or complete.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_ YES \_\_\_\_\_ NO

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that Jackson Health System, under certain circumstances, may deny my request for amendment/correction. Further, I understand that if Jackson Health System denies my request for amendment/correction, he/she will provide a written denial outlining the basis for the denial.

\_\_\_\_\_ Signature of Patient \_\_\_\_\_ Legal Representative

\_\_\_\_\_ Date

If Legal Representative, state relationship: \_\_\_\_\_



MIAMI, FLORIDA 33136-1096

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PROTECTED HEALTH INFORMATION**

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AFFIX PATIENT LABEL HERE  
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**For Administrative Use Only**

Date Request Received: \_\_\_\_\_

Amendment/Correction has been: \_\_\_\_\_ Accepted \_\_\_\_\_ Denied

\_\_\_\_\_ *In response to your request, an amendment/correction will be made part of your permanent medical record.*

\_\_\_\_\_ *Your request has been denied for the following reason(s):*

- \_\_\_ Information was not created by this organization.
- \_\_\_ Information is not part of the patient's health record.
- \_\_\_ Federal law or state law limits patient's right of access to inspect and receive a copy of protected health information (e.g. psychotherapy notes that have been separated from the rest of the medical record or are under a physician order limiting patient access).
- \_\_\_ Information is accurate and complete.
- \_\_\_ Other: \_\_\_\_\_

Signature of Staff Person \_\_\_\_\_ Date \_\_\_\_\_

Print Name and Title \_\_\_\_\_

**Statement of Disagreement**

*If you do not agree with the above information, you may submit a Statement of Disagreement that will become part of your permanent record and included in any future disclosure of the subject medical information. Please outline the reason for your disagreement in the space provided below (may attach no more than 2 pages) and return to:*

*Chief Privacy Officer  
Jackson Health System  
Jackson Medical Towers  
1500 N.W. 12<sup>th</sup> Avenue, Suite 102  
Miami, Florida 33136*

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WHITE: MEDICAL RECORD

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AFFIX PATIENT LABEL HERE  
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CANARY: PRIVACY OFFICER