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: _____

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. 12th Avenue, Suite 102
Miami, Florida 33136

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