1. Patient name: _____ Date of Birth: _____

2. Describe the amendment / correction you are requesting of Tampa General Hospital on information contained in your medical record. Please attach more sheets as needed to completely describe your request.

_____

_____

_____

3. **Acknowledgement**: By submitting this form, I hereby request the Organization to amend/correct my health information as described above. I understand and acknowledge that the Organization is not required to agree to my request. I understand and acknowledge that a response is required within 90 days of my request. If my record is amended, I understand and acknowledge that the Organization will notify the relevant persons with whom the amendment needs to be shared.

Print name of patient or representative: _____

Signature: _____ Date: _____

4. Return this Amendment/Correction form and any additional attached sheets by mail or fax.

Mail to: Tampa General Hospital
HIM Department - Data Integrity Team
P.O. Box 1289
Tampa, FL 33601

Fax to: 813-844-1239

To be completed by authoring provider / Health Information Management Department

Physician / Caregiver Response:

☐ **This request has been denied. No change to the original documentation because the documentation:**

☐ **Is accurate** ☐ **Was not created by us**

☐ **This request has been accepted. Addendum to record, if accepted:** _____

_____

Name: _____ Signature: _____ Date: _____

For Tampa General Hospital use only

❒ Request received in HIM on: _____ by: _____	❒ Authoring Provider notified Delivered to: _____ on _____ via _____	❒ Response received in HIM department Date: _____

Request for Amendment/ Correction of Health Information by Tampa General Hospital

Tampa General Hospital

Form #: R566 Rev. 6/4/2021

White - HIM Dept. Yellow - Patient / Representative

Patient Information