1. Patient name: _____ Date of Birth: _____

2. Date of request: _____

3. Describe the amendment / correction you are requesting of Tampa General Hospital on information contained in your medical record.

_____

_____

_____

_____

4. Information on your rights to request an amendment / correction: You have the right to request an amendment / correction for as long as the information is kept by or for the hospital (See Notice of Privacy Practices.) We may deny your request for an amendment / correction if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend / correct information that:

   - Was not created by us;
   - Is not part of the medical information kept by or for the hospital;
   - Is not part of the information which you would be permitted to inspect and copy; or
   - Is accurate.

5. 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.

Print Name of patient or representative: _____

Signature: _____ Date:

To be completed by authoring provider

Physician / Caregiver Response:

No change to original documentation because the original information:

❒ Was not created by us ❒ Is not part of medical Info kept by/for hospital ❒ Is not part of Info which you are permitted to inspect and copy ❒ Is accurate

❒ Addendum to record: _____

_____

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: _____

Patient Information

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

Tampa General Hospital

White - HIM Dept. Yellow - Patient / Representative