AMENDMENT/CORRECTION OF HEALTH RECORD REQUEST FORM

FLORIDA DEPARTMENT OF ELDER AFFAIRS
4040 ESPLANADE WAY
TALLAHASSEE, FLORIDA 32399-7000

Client Name: _____

Phone Number (day): _____

Phone Number (night): _____

Street or PO Box: _____

City: _____

State: _____

Zip: _____

1) Date of Medical Record Entry to be Corrected: _____

2) Medical Record Language to be Amended/Corrected: _____

3) Amendment/Correction:

4) Reason for the Amendment/Correction:

5) Identify persons who have received the Information (prior to Amendment/Correction):

Name Organization/Address Phone Number

6) Do you authorize us to provide the information in Items no. 3 and no. 4 to the persons and organizations listed in Item no. 5?

Yes _____

No, do not provide the information to: _____

TO OUR CLIENTS: You have the right to submit a Medical Record Amendment/Correction Form to be made a part of your medical record. This right does not permit you to alter or change the original record created by your health care provider or his/her staff. We may deny your request to amend or correct your records.

Amendment/Correction Accepted: _____

Amendment/Correction Denied: _____

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Reason for Denial: _____
_____
_____
_____
_____
_____

This Amendment/Correction Sheet Is to Be Made a Part of the Medical Record of:

Client Name: _____

Date: _____

Signature of Client: _____

If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in Items # I and # 2 above.

Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice Of Privacy Practices" or our legal obligations under state or federal law, you may contact the Privacy Officer, General Counsel, of our office regarding your complaint. You may also file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.

Privacy Officer, Office of the General Counsel
Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
(850) 414-2000

Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 3B70
61 Forsyth Street S.W.
Atlanta, Georgia 30303-8909
Voice Phone: (404) 562–7886
FAX: (404) 562-7881
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