# Request for Amendment of Medical Record

| Patient Name | Date of Birth | Medical Record Number, if known |
|---|---|---|
| Address, City, State & ZIP | | |
| Telephone # ( ) | Legal Authority: ☐ Parent ☐ Legal Guardian ☐ Other: | |

***Amendment Information:*** *Complete all three areas below with as much detail as possible. Attach additional information as necessary to describe the event(s).*

| | |
|---|---|
| Date(s) of entry/entries to be amended (e.g. date of office visit, admission). | |
| Describe entry you want amended (e.g. lab test results, physician notes. | |
| Describe how the entry is incorrect or incomplete. | |
| How should the entry be amended to be more accurate? | |
| If amendment is accepted, do we have your permission to share amendment with individuals who received this information? Circle one: **YES NO** If yes, please provide name(s) and Address(es) of the organization(s) or individual(s) below. | |

**Signature of patient/patient representative:** ______________________ **Date:** __________

**Please send this completed form to the correct facility below. Keep a copy for your records.**
UF Health Shands: PO Box 100345, Gainesville, FL 32610-0345. Phone 352.265.0131 Fax: 352.265.1097.
UF Health Shands Psychiatric Hospital or UF Health Shands Rehab Hospital: 4101 NW 89th Blvd., Gainesville, FL 32606.
Phone: 352.265.5497, x70069 Fax: 352.265.5426

**FOR UF HEALTH SHANDS USE ONLY**

| **Amendment was:** | ☐ Accepted as-is<br>☐ Accepted in part | ☐ Denied *and* Reason for denial: | ☐ PHI is accurate and complete<br>☐ PHI not created by UF Health Shands<br>☐ PHI not part of designated record set<br>☐ PHI is not available for inspection |
|---|---|---|---|

Health Care Reviewer Comments: ______________________

Signature- Health Care Reviewer: ______________________ Date ______________________

☐ Patient has **not** filed a Statement of Disagreement, but requests future releases include requested amendment and denial information.
☐ Patient filed a Statement of Disagreement, must be released along with other documentation with future releases of information.
☐ Facility / provider appended written response / rebuttal and forwarded to patient.
☐ Facility / provider did not provide a response / rebuttal.

Signature of HIM Representative ______________________ Date ______________________

*Check facility*

☐ UF Health Shands
PO Box 100345, Gainesville, FL 32610-0345
Phone: 352.265.0131 Fax: 352.265.1114

☐ UF Health Shands Rehab Hospital
4101 NW 89th Blvd., Gainesville, FL 32606
Phone: 352.265.5491, x70069 Fax: 352.265.5426

☐ UF Health Shands Psychiatric Hospital
4101 NW 89th Blvd., Gainesville, FL 32606
Phone: 352.265.5497, x70069 Fax 352.265.5426