Medical Record Number (if applicable): ____________________

Facility: ____________________ Department: ____________________

It is Broward Health's (BH) belief that an essential part of customer service is accurate and complete documentation of your care and diagnoses. You, therefore, have the right to request to amend any medical information that you feel is invalid. BH, however, reserves the right to refuse the request if the request fails to meet the criteria defined in the law. Complaints regarding denials may be filed, in writing, to: Broward Health Privacy Officer, 1800 N.W. 49th Street, Fort Lauderdale, FL 33309.

PLEASE COMPLETE SECTIONS I AND II ONLY

SECTION I: PATIENT INFORMATION

Patient Legal Name: ____________________ / ____________________
Last First Middle Initial Maiden

Address: ____________________
Street City State Zip Code

Birth Date: ____/____/____ Telephone: ____________________

SECTION II: REQUEST FOR AMENDMENT

I, ____________________, request that BH amend the following medical Information belonging
Patient / Personal Representative ***(please circle one)***
to the patient named in SECTION I of this form.

Location of change in medical record: ____________________

Change From ***(Information to be corrected)***: ____________________

____

____

Change To ***(Correct Information)***: ____________________

____

____

Signature of Patient/Patient Representative ____________________ Date: ____/____/____

SECTION III: TO BE COMPLETED BY ATTENDING PHYSICIAN, MEDICAL RECORD MANAGER, OR DESIGNEE (AUTHORIZED BH STAFF ONLY)

Status of request (Check one):

_____ Approved.

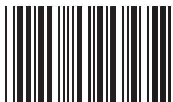
_____ Denied. Please check reason for denial below:

- _____ Information was not created by BH.
- _____ Information is not available for review.
- _____ Information has been deemed accurate and complete.
- _____ Information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative action.

Authorized Signature: ____________________ Please Print Name: ____________________ Date: ____/____/____

ADDRESSOGRAPH

REQUEST TO AMEND



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BROWARD HEALTH®

REQUEST TO AMEND MEDICAL INFORMATION

Copy Distribution: White — Medical Records Canary — Patient