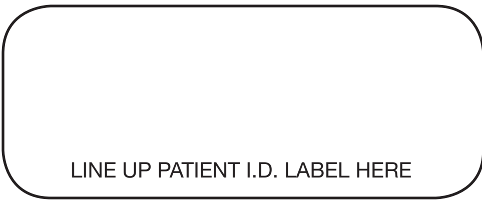
ORLANDO HEALTH®

Mailing Address: 1414 Kuhl Ave. • Orlando, FL 32806

REQUEST FOR AMENDMENT OF THE DESIGNATED RECORD SET
(Page 1 of 2)



Patient name: ______________________ Patient date of birth: ______________________

Location of request: ______________________ Medical record/Account number: ______________________

Requestor name: ______________________ Relation to patient: ______________________

Address: ____
(Street) (Apt) (City) (State) (Zip)

Phone: (_____) _____-________

Dates of service: ______________________ Facility/Provider: ______________________

Document(s) to be amended: ______________________

Please explain how you believe the document is incorrect or incomplete. What should the document say or what should be added to the document? (Attach additional pages and/or documentation if necessary.)

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Please list anyone to whom we may have released this information in the past and to whom you would like us to send this amendment, if accepted:

____
(NAME) (ADDRESS) (Apt/Suite) (City) (State) (Zip)

____
(NAME) (ADDRESS) (Apt/Suite) (City) (State) (Zip)

I understand that my Request for Amendment will be reviewed by Orlando Health and may be accepted or denied. I will be notified in writing of the status of the amendment at the address listed above within 60 days of my request. If accepted, I authorize the release of this amendment and the associated information from the designated record set to be released to the persons/entities listed above.

______________________________ ____________ ____________
Signature of patient or authorized representative Date Time

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LINE UP PATIENT I.D. LABEL HERE

Request received by: ____ Date: _____/_____/____

Title: ___________________________ Department: ____

Does this request affect records that originated at an Orlando Health facility or one of its affiliates?
❑ Yes ❑ No (If no, proceed to denial process.)

Records affected by this request reside with:
❑ Health Information Management
❑ Patient Financial Services
❑ Orlando Health Physician Enterprise (Office:____)
❑ Rehabilitation Services (Location: ____)
❑ Other: (Name and location:____)

Practitioner or department that created record to be amended:__________________________________

Representative of practitioner or department who reviewed request: ____________________________

Accepted
❑ The amendment is approved as submitted.

Other persons or entities who may have relied on the inaccurate document

____

Denied
❑ PHI did not originate at Orlando Health or one of its affiliates.
❑ PHI is not part of the designated record set.
❑ PHI is not available to the patient for inspection as required by federal law.
❑ Other (document reason below):

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____ ______________ ____________
Signature of reviewer Date Time

COMMUNICATION ASSISTANCE PROVIDED (Please Print)		
QUALIFIED INTERPRETER	**QUALIFIED BILINGUAL TEAM MEMBER**	**ASSISTING VISUALLY IMPAIRED**
Team Member Name & I.D.: ____________________ Agency/Interpreter Name and/or I.D.: ____________________ ☐ Video remote ☐ Tel ☐ In-person Language: ____________	Team Member Name & I.D.: ____________________ Language: ____________________	Team Member/Reader Name & I.D.: ____________________ Other: ____________________