1. Patient name: _____ Date of Birth: _____

2. Describe the amendment / correction you are requesting of Tampa General Hospital on information contained in your medical record. Please attach more sheets as needed to completely describe your request.

3. **Acknowledgement**: By submitting this form, I hereby request the Organization to amend/correct my health info described above. I understand and acknowledge that the Organization is not required to agree to my request. I and acknowledge that a response is required within 60 days of my request. If my record is amend

Print name of patient or representative: _____

Date: _____ Signature: _____

To be completed by authoring provider / Healt

Physician / Caregiver Response:

☐ **This request has been denied. No change to the original doc**

☐ **Is accurate** ☐ **Was not created by**

☐ **This request has been accepted. Addendum to**

Name: _____ Signature: _____

For Tampa General Hospital use only

Request received in HIM by: _____

Delivered to: _____ on _____ via _____

Response sent from HIM department

Date: _____

Patient Information

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

Form #: R566 Rev. 2/11/2020

White - HIM Dept. Yellow - Patient / Representative