MARTIN HEALTH SYSTEM

Instructions for Requesting a Correction/Amendment of Protected Health Information

To begin the Correction/Amendment process, please complete the attached request form. At site, return to the designated person; if completed at home, please mail to:

Martin Health System
Health Information Management
PO Box 9010
Stuart, FL 34995

Once the completed request is received, you will receive written notification of the outcome within sixty (60) days. If determination can not be made within sixty (60) days, a written status update and agreement to make a determination within the next thirty (30) days will be sent.

If you have any questions, please feel free to contact Health Information Management at (772) 223-5945 ext. 13070.

MARTIN HEALTH SYSTEM

Request for Correction/Amendment of Protected Health Information

Patient Name:________________________________ Date:_____________ DOB: ___/___/____
Medical Record#:____________ Phone Number: _________________ Last 4 of SS#: _______
Patient Address:____
Date(s) of Service to be amended:____

1. Describe the information you want amended: ____
____
____

2. Explain how this information is incorrect or incomplete. Include the information that you feel should be included in order to make the record more accurate or complete. ______________________________
____
____
____

3. Would you like this amendment sent to anyone to whom we have disclosed the information to in the past? If so, please specify the name and address of the organization or individual: ______________________
____
____
____

I understand the Physician/Individual may or may not supplement the medical record with an amendment based on my request, and under NO circumstances, is able to alter the original documentation of the medical record. In any event, this request for an amendment will be made part of my permanent medical record and will be sent as part of the medical record in response to any authorized requests of my medical information.

_____________________________________ __________________ ___________________
SIGNATURE (Patient or Legal Representative) (Relationship) DATE

Amendment/Correction Response

_____ A correction/amendment will be made part of your medical record.

_____ A partial correction/amendment will be made part of your medical record.

____ Your request has been made a part of your permanent medical record; HOWEVER, your request has been Denied for the following reason(s):
____ The health information in question was not created by MHS
____ The health information is not a part of MHS medical record
____ The health information is accurate and complete
____ The health information is not accessible by the patient (i.e. Psychotherapy notes, information compiled in anticipation of litigation, information prohibited by law under Clinical Laboratory Improvement Act.)
____ Other : ____

Signature of Healthcare Provider:__________________________________ DATE:_________________

Print Name & Title____

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