Cleveland Clinic
Martin Health

Instructions for Requesting a Correction/Amendment of Protected Health Information

To begin the Correction/Amendment process, please complete and forward the attached request form to the Medical Records office at your current Cleveland Clinic Martin Health location. If completed at home, please mail to:

Cleveland Clinic Martin Health
Health Information
Management P.O. 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 cannot be made within sixty (60) days, a written statement for the reasons for the delay 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

Cleveland Clinic
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Request for Correction/Amendment of Protected Health Information

Patient Name: _____ **Date:**____/____/____ **DOB**: ____/____/____

Medical Record #: _____ **Last 4 of SSN**: _____ **Phone**: ____-____-____

Address:

_____

Date(s) of Service to be amended: _____

A. Describe the information you want amended: _____

_____

B. Explain how this information is incorrect or incomplete. Include the information that you feel should be included to make your record accurate or complete.

_____

_____

C. 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 may be made part of my permanent medical record and may be sent upon written request as part of the medical record in response to any authorized requests of my medical information.

_____ _____ _____

Signature (Patient or Legal Representative) **Relationship** **Date**

Administrative Use Only

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 <u>Denied</u> for the following reason(s)**:

- ____ The health information in question was not created by CCMH.
- ____ The health information is not a part of CCMH 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 the Clinical Laboratory Improvement Act).
- ____ Other: _____

Signature of Healthcare Provider: _____ **Date**: _____

Print Name & Title: _____