Lakeland Regional Health®

REQUEST FOR CORRECTION/AMENDMENT TO HEALTH INFORMATION

Date of Request: _____ MRN: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Describe the amendment/correction to information contained in your medical record that you are requesting of Lakeland Regional Health. Include the date and name of the document.

_____

_____

_____

_____

_____

_____

Acknowledgement: By submitting this form, I hereby request Lakeland Regional Health to amend/correct my health information as described above. I understand and acknowledge that Lakeland Regional Health is not required to agree to my request. I understand and acknowledge that a response is required within 90 days of my request.

Print name of patient or representative: _____

Signature: _____ Date: _____

To be completed by authoring provider

Physician/Caregiver Response:
No change to original documentation because the original information:

- ☐ Was not created by us
- ☐ Is not part of the medical information kept by/for the hospital
- ☐ Is accurate
- ☐ Is not part of information which you are permitted to inspect and copy
- ☐ Addendum to record: _____

_____

Signature: _____ Date: _____

For LRH Health Information Management Use Only

Request received in HIM on: _____ by: _____

Authoring provider notified on: _____ via: _____

Response received in HIM department on: _____ by: _____