CenterWell
Senior Primary Care

6350 West Colonial Drive
Orlando, FL 32818
PH: 866-222-0403

Medical Record Amendment/Correction Form

PATIENT INFORMATION:		
Last Name:		First Name:
Address:		
City:	State:	Zip Code:
Phone Number:	Date of Birth:	
Facility Name:		

1. Date of Medical Record Entry to be Corrected: _____

2. Medical Record Language to be Amended/Corrected: _____

3. State the reason for the Amendment/Correction: _____

4. Date of Medical Record Entry to be Corrected: _____

5. Please help us identify persons who have received the information prior to the Amendment/ Correction:

Name	Address	City, State Zip	Telephone

6. Do you authorize us to provide the information in items number "3" and "4" to the person(s)/organization(s) listed in number "5"? ☐ Yes ☐ No

Do not provide the information to: _____

You have the right to submit a Medical Record Amendment/Correction to your record. This right does not permit the alteration or change the original record created by your physician or his/her staff. We maintain the right to make a determination regarding this request and will notify you of the decision within 60 days upon receipt of this request.

Signature of Patient: _____ Date: _____

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Patient Name: _____
Last Name First Name DOB

OFFICE USE ONLY

Date Request Received: _____ Amendment/Correction ☐ Accepted ☐ Denied

Reason for Denial:

☐ Information Is not part of the patient's designated Record set
☐ Information was not created by this organization
☐ Information is not available to the patient for access as required by federal law
☐ Information is complete and accurate

_____ _____
Associate's Name: (Print) Title

_____ _____
Associate's Signature Date Completed

If we have denied your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. We may reasonably limit the length of your written statement, and we may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).

If we have denied your requested amendment/correction and you do not submit a written statement of disagreement as discussed above, you may request that we include a copy of this document with any future disclosures of the information identified in Items no. 1 and no. 2 above. Please make your request in writing, and sign and date the request.

If you believe we have failed to meet our obligations as explained in our "Notice Of Privacy Practices" or our legal obligations under state or federal law, you may contact the Clinic Administrator of our office regarding your complaint, and you may file a complaint with Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.