**Jupiter Medical Center**
**Jupiter, FL 33458**

# Jupiter Medical Center
## Request for Amendment of or Addition to Health Information

**Contact Person: Susan Denny, Director of Medical Information Services**
**Phone: (561) 263-7414**

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in the request for all future disclosures.

I, _____ (print name) believe that the following health information pertaining to me is incorrect or incomplete (please copy below or attach the challenged entry and identify location):

_____
_____
_____
_____
_____

I believe that the information described above is incomplete or incorrect for the following reasons:

_____
_____
_____
_____
_____

I hereby request that you amend the health information identified above as follows:

_____
_____
_____
_____
_____

Additionally, I request that the following people be notified of the correction:

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |
| | |

Name: _____ Date: _____



**Form #jmcO475 Rev. 5/09, 11/09, 11/11**

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### Notification to Requestor:

We will not make the requested changes if:

1. They involve records that you have no right to access; or
2. We did not create the information (unless the person or entity that created the information is unable to act on your request); or
3. The information is already accurate and complete

If we agree to change your information, we will communicate the changed information to the persons or entities that you have designated above. We will also communicate the changed information to any other persons or entities that we know have received the information before it was amended. If we are not able to act on the request in 60 days, we will notify you of the reason for the delay.

Name: _____

Address: _____

Telephone: _____

Social Security Number: _____

Date of Services Provided: _____

_____ _____
Requestor's Signature Date

_____ _____
Print Name Relationship to patient

Name: _____ Date: _____