Jacksonville Fire and Rescue Department

Duval County, Florida

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

As allowed under Federal law, 42 CFR § 164.526, if you think the information in your medical or billing record is incorrect, you can request an amendment. Amendment requests can be submitted via mail, fax, email or in person to:

Jacksonville Fire and Rescue Department
Records Custodian
515 N. Julia Street
Jacksonville, FL 32202
Fax: (904) 630-4202
Email: JFRDRecordsRequest@coj.net

1. The patient information on this form must match the information documented in the patient care report.
2. A government issued ID is required when submitting request in person.
3. If any person other than the patient is signing this request, documentation of authority must be provided.

PATIENT INFORMATION

Patient Name: _____ Date of Request: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Date of Birth: _____

INCIDENT REPORT INFORMATION

Date of Incident: _____ Incident Address: _____

INFORMATION TO AMEND

Please check the field that represents the type of information you would like amended: (check all that apply)

☐ Name
☐ Billing Address
☐ Mailing Address
☐ Current Medications
☐ Past Medical History
☐ Allergies
☐ Current Medical Condition
☐ Other: Please describe _____

DESCRIPTION OF INFORMATION YOU WANT AMENDED

Please specifically describe what information you want amended and ONLY list new information. _____

As your health care provider, we, the Jacksonville Fire and Rescue Department must respond to your request within 60 days and amend any inaccurate or incomplete information that we created. If we do not agree to your request, you will be notified. You will then have the right to submit a statement of disagreement that we will add to your record.

SIGNATURE OF PATIENT

Falsifying a request to amend medical information is a crime under federal law.

Patient/Parent/Legal Guardian Signature	Relationship	Date

FOR JFRD USE ONLY	Request Received by	Date