Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ Work Phone: (___) _____

I have reviewed my health record; I do not feel the information in the record made by

_____ is correct.

(Name of provider)

This date(s) of service _____ should be updated with the following information:

_____

_____

_____

This form may be returned to Scheurer Hospital HIMS (medical records) or mailed directly to Scheurer Hospital- HIMS 170 N. Caseville Rd., Pigeon, MI 48755 or faxed to (989)453-4455.

Signature: _____ Date: _____

Provider Response

☐ An amendment will be made to your permanent health record.

☐ This request for an amendment has been made a part of you permanent record; however, your request to amend your health record directly has been denied for the following reasons:

_____

_____

_____

Provider Signature: _____ Date: _____

If you disagree with the provider, you may submit a written statement of disagreement.

(Attach copy of Statement of Disagreement for Patient)

Scheurer
Better Health. Better Life.

RECORD AMENDMENT REQUEST

Form# 1062 *Revised: 11/09/2017*