Please complete the top portion of this form with details about any requested corrections or additions.

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.

(Write the name of the provider above that documented the information you intend to have corrected)

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

_____

_____

_____

This form must be returned to Scheurer Health Information Management Services (medical records), mailed directly to Scheurer - HIMS 170 N. Caseville Rd., Pigeon, MI 48755, fax to (989)453-4455 or email to Scheurer_HIMS@scheurer.org. Please allow thirty (30) days to process your request.

Signature: _____ Date: _____

(INTERNAL USE ONLY) 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 Health

RECORD AMENDMENT REQUEST

Form #1062
Revised: 07/21/2020