SCHEURER HOSPITAL

Request to Amend/Correct Protected Health Information

I hereby request the opportunity to amend my personal health information maintained by Scheurer Hospital (*Please add additional pages if necessary.)*

Describe the information you want amended (example: Discharge summary, physician notes, etc): _____

_____

The date of the information to be amended (example: date of office visit, treatment, date report written): _____

My reason for making this request is _____

How is the entry incorrect, incomplete, or outdated? _____

_____

What should the entry say to be more accurate or complete? _____

_____

Do you know of anyone who may have received or relied on the information in question (such as our doctor, pharmacist, health plan, or other health care provider)? ___No___Yes
If yes, please specify the name and addresses of the organization(s) or individual(s): _____

_____

_____

PATIENT NAME: (printed)_____DOB_____

_____

Street City State Zip Phone Number

_____

Patient Signature (Relationship) Driver's License Date

_____

Witness Signature Date

PHYSICIAN OR HEALTHCARE PROVIDER RESPONSE

Request to Amend/Correct Protected Health Information

___ In response to your request, a correction/addendum will be made part of your permanent medical record.

___ Your request has been denied; however, your request has been made part of your permanent medical record. The reason your request is denied:

_____

_____

_____

_____

_____ _____

Physician/provider signature Date

_____

Physician/provider name Please Print