St. Clair County Community Mental Health Authority

Request for Amendment of Protected Health Information

This request for amendment concerns records created and maintained by St. Clair County Community Mental Health Authority (SCCCMHA). Consider the following when requesting an amendment:

1. SCCCMHA can only amend records that were created by the Agency.
2. SCCCMHA will only amend records if they are found to be inaccurate or incomplete, unless otherwise stated by the Michigan Mental Health Code (MHC)*****.
3. Supporting information regarding the amendment should be attached to this request for further clarification.

***Per the Michigan Mental Health Code, Section 330.1749: Statement Correcting or Amending Information:**
"A recipient, guardian, or parent of a minor recipient, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the recipient's record. The recipient, guardian, or parent of a minor recipient shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record."

To request an amendment, please fill out this form in its entirety. You may mail, fax, or deliver the form in person.

Section I – Patient Information

Individual: ______________________________ Date of Birth: ______________

Address: ______________________________ City: __________ State: ____ Zip: __________

Telephone #: ____________________

If you are not the individual named above, please fill out the information below:

Please indicate your relationship to the individual above:

☐ Parent of Minor ☐ Guardian ☐ Other *(please specify):* ______________________________

Name: ______________________________ Telephone #:______________

Please provide your address, if different from the individual's above:

Address: ______________________________ City: __________ State: ____ Zip: __________

Section II – Description of Health Information You Are Requesting to Amend:

Type of record to be amended: *(select all that apply)*

☐ Discharge Summary ☐ Assessment
☐ IPOS ☐ Medication Review
☐ Psychiatric Evaluation ☐ Progress Note
☐ Lab Results ☐ Other *(please specify):* ______________________________

Provide the date(s) of the record(s) to be amended: *(i.e., Date of Office Visit, Date of Treatment, etc.)*

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Please explain how the entry is incorrect or incomplete. Include the information you feel should be included in order to make the record more accurate or complete. Please attach any supporting documentation to this form, if applicable.

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Section III – Signature

______________________________	______________________________	__________
Individual Signature	Print Name	Date
______________________________	______________________________	__________
Parent/Guardian Signature *(if applicable)*	Print Name	Date

PLEASE SUBMIT COMPLETED FORM TO:
Corporate Compliance/Recipient Rights
St. Clair County Community Mental Health Authority
3111 Electric Avenue
Port Huron, MI 48060

SCCCMHA Use Only: OASIS Case #: ______________ Received Date: _________________

Clinical Form: #03-0917
Revised Date: 5/1/2024
Policy Ref: #08-003-0005
EHR: Administrative/Financial, Other Administrative/Financial Documents Note: Request for Amendment of Protected Health Information