

# Bangs Ambulance

## Request for Amendment of Protected Health Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Information to Amend:**

Please check the field that represents the type of information you would like to amend.

- |  |   |
|--|---|
| <input type="checkbox"/> Name                      | <input type="checkbox"/> Marital Status           |
| <input type="checkbox"/> Billing Address           | <input type="checkbox"/> Surrogate Decision Maker |
| <input type="checkbox"/> Mailing Address           | <input type="checkbox"/> Organ Donor              |
| <input type="checkbox"/> Current Medical Condition | <input type="checkbox"/> Other: Please describe   |
| <input type="checkbox"/> Past Medical History      | _____   |
| <input type="checkbox"/> Current Medications       | _____   |
| <input type="checkbox"/> Allergies                 | _____   |

Please specifically describe what information you wanted amended. Please ONLY list the new information. Attach a separate sheet if necessary.

---

---

---

---

---

---

---

Bangs Ambulance, in its capacity as a health care provider, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied until such time as the amended information becomes effective. Bangs Ambulance is not required to accept your request for amendment and will notify you in writing as to the decision on your request.

Your signature below indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to Bangs Ambulance based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_