ELY AREA AMBULANCE SERVICE
Patient Request for Amendment of Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

Right to Request Amendment of Your PHI and Our Duties:

You (or your authorized representative) have the right to ask us to amend protected health information (PHI) that we maintain about you in a designated record set. When required by law to do so, we will amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information in certain circumstances, such as when we believe the information you have asked us to amend is correct. ELY AREA AMBULANCE SERVICE is entitled to perform and bill for services based on PHI in its current form or upon which it has already relied until such time as the amended information becomes effective.

Request for Amendment of PHI:

Below, please describe the PHI that you are requesting us to amend and how this information should be amended with as much specificity as possible. Specify dates of service and other details that will allow ELY AREA AMBULANCE SERVICE to accurately and completely fulfill your request.

_____

_____

_____

Signature of Requestor: _____ ***Request Date:*** _____

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____