Adair County Ambulance District
Request for Amendment of Protected Health Information

Patient Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Information to Amend:

____ Name
____ Billing Address
____ Mailing Address
____ Current Medical Condition
____ Past Medical History
____ Current Medications
____ Allergies

____ Marital Status
____ Surrogate Decision Maker
____ Organ Donor
____ Other: Please describe.
_____
_____
_____

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

Adair County Ambulance District, 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. Adair County Ambulance District 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 Adair County Ambulance District based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: _____ *Date:* _____