Pasco County Fire Rescue

Request for Amendment of Protected Health Information

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Amend:
Please check the field that represents the type of information you would like to amend. Additional pages may be added if necessary.

Patient Information:

___ Name
___ Personal Information(i.e., SSN,DOB, Ins., etc.)
___ Mailing Address
___ Marital Status
___ Surrogate Decision Maker or POA
___ Other (Please Describe): _____
_____
_____
_____

Call Information:

___ Medical Condition
___ Medications
___ Medical History
___ Allergies
___ Treatments Received
___ Symptoms
___ Specify which call(s):
_____, _____,
_____, _____

Please specifically describe what information you wanted amended. Please ONLY list the new information. (Attach additional sheets if necessary)

PCFR is not required to accept your request for amendment and will notify you in writing as to its decision on your request.

Please allow sixty (60) days for the amended information to become effective.

PCFR, 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.

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

Patient Signature: _____ Date: _____