SABLE-ALTURA FIRE PROTECTION DISTRICT

Request for Amendment of Protected Health Information

Patient Name:_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Date of Birth:_____ Social Security Number:_____

Information to be amended:
Please check below all that apply to the information you would like 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 below
_____
_____
_____

Please describe exactly what information you wish to be amended. Please list ONLY the new information. Attach a separate sheet if necessary.

_____
_____

Please list all individuals and companies you wish to be notified of your amended information, including hospitals, other ambulance transport agencies, etc. Attach a separate sheet if necessary.

_____
_____

Sable-Altura Fire Protection District (the "District"), in its capacity as a health care provider, is allowed to provide and bill for services based on all protected health information in its current form, or the information it already has, until such time as the amended information takes effect. The District is not required to accept your request for amendment. The District will notify you in writing of its decision on your request.

Your signature below indicates that you agree to the terms above and, further, to provide payment for the services the District has provided, if required, to the District based on your existing protected health information, unless and until the amendments you have requested become effective.

Patient Signature:_____ Date:_____