

**Form 13: Request for Amendment of Protected Health Information**

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Hebron Fire Department  
Request for Amendment of Protected Health Information

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Information to Amend:**

____ Name	____ Marital Status
____ Billing Address	____ Surrogate Decision Maker
____ Mailing Address	____ Organ Donor
____ Current Medical Condition	____ Other: Please describe.
____ Past Medical History	_____
____ Current Medications	_____
____ Allergies	_____

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

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Hebron Fire Department, 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. Hebron Fire Department 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 Hebron Fire Department based on existing protected information until such time that the amendments you have made are effective.

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