PURPOSE:

Patients form for requesting amendment to protected health information.

INDIVIDUAL RESPONSIBLE FOR COMPLETING:

Person requesting amendment to protected health information.

WHEN FORM IS TO BE COMPLETED:

At the time of the request to amend protected health information.

INSTRUCTIONS FOR COMPLETING:

The patient will complete and sign the form.

ROUTING:

Completed forms will be directed to the HIPAA Privacy Officer.

RETENTION:

The form will be retained with the PPCR.

COPIES TO:

No additional copies required.

TOWN OF CHILHOWIE FIRE DEPARTMENT

HIPAA Request for Amendment of PHI

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Amend: Please check the field that represents the type of 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

_____

_____

_____

Please specifically describe what information you want amended. Please ONLY list the new information.

Please allow 10 business days for the amended information to become effective.

The Town of Chilhowie 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.

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

Patient Signature: _____ *Date:* _____