COSHOCTON COUNTY EMS
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION
ATTACHMENT D

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 wanted amended. Please ONLY list the new information. Attach a separate sheet if necessary.

_____

_____

Coshocton County EMS 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. Coshocton County EMS 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 Coshocton County EMS based on existing protected information until such time that the amendments you have made are effective.

Signature: _____ ***Request Date:*** _____