Polson/ Ronan Ambulance Service, Inc
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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Polson/ Ronan Ambulance Service, Inc 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. Polson/ Ronan Ambulance Service, Inc 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 Polson/ Ronan Ambulance Service, Inc based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: **_________________________________** ***Date:*** **___________**