LifeCare Ambulance Medical Services
Request for Amendment of Protected Health Information

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. Additional pages may be added if necessary.

Patient Information:

- ☐ Name
- ☐ Personal Information(i.e SSN, DOB, Ins. Info.,etc.)
- ☐ Mailing Address
- ☐ Marital Status
- ☐ Surrogate Decision Maker or POA
- ☐ Other(Please describe):______________________

____
____
____
____

Call Information:

- ☐ Medical Condition
- ☐ Medications
- ☐ Medical History
- ☐ Allergies
- ☐ Treatments received
- ☐ Symptoms
- ☐ Hospital Treatment/DX

Specify which call(s):
________ , ______
________ , ______

Please specifically describe what information you wanted amended. Please ONLY list the new information.(Attach additional sheets if necessary)

LEMS is not required to accept your request for amendment and will notify you in writing as to it's decision on your request.

Please allow 60 days for the amended information to become effective.

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

Patient Signature: ______________________________________ Date: _______________