Clayton Fire Department
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.

_____ 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 how you want your current information amended and the reason(s) for the amendment. Please list ONLY the new information you want included, together with the reason(s) for the changes. Attach a separate sheet if necessary.

_____

_____

_____

_____

Clayton Fire Department, in its capacity as a health care provider, is entitled to rely on all protected health information in its current form or upon which the Department has already relied until such time as the amended information becomes effective. Clayton 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 on this form indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to Clayton Fire Department based on existing protected health information until such time as the amendments you have requested are made and effective.

<OVER>

Signature of Patient:	
Please print name:	Date:

— OR —

Signature of Authorized Representative:	
Please print name:	Date:
Please explain Representative's authority to act on behalf of the Patient: _____ _____ If Representative's authority to act on behalf of the Patient is based on a written document, please attach a copy of such written document to this Request.	

State of _____)
) SS
County of _____)

On this _____ day of _____, 20___, before me personally appeared _____, to me known to be the person described in and who signed this Request for Amendment of PHI, by reviewing his/her driver's license and witnessing his/her execution hereof, and who acknowledged that he/she signed it voluntarily as his/her free act and deed, with full authority to make this request under federal and state law.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year above written.

_____
Notary Public

My Commission Expires: