

**Lake-Sumter Emergency 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)

LSEMS 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.

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

Patient Signature: _____

Date: _____