Request for amendment of medical records

Patient Name: (print) ____________________

Street/PO Box: ____________________

City/State/Zip: ____________________

Information to Amend:

Incident No. ____________________

Please check the field that represents the type of information you would like to amend.

- ☐ Name
- ☐ Address
- ☐ DOB
- ☐ Other, please describe:
- ☐ Medical History
- ☐ Allergies
- ☐ Medications

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Please specifically describe what information you want amended. Please ONLY list the new information.

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Please allow 30 days to process this request. Hillsboro Fire & Rescue is not required to agree to any amendments requested by the patient; however any amendments agreed to are binding.

____________________ Signature of Patient or Other Person Authorized to Sign for Patient

____________________ Date

____________________ Relationship to Patient

____________________ Printed Name

FOR HILLSBORO FIRE AND RESCUE USE ONLY
Date received:__________ **Received by:**__________ **Paid:**__________ **Check #:**__________

□ **Approved by EMS office.** □ **Denied. Reason for denial:**____________________
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Initials and Date:____________________ **Referred to:**____________________