

CHESTER AMBULANCE SERVICE

PO Box 370
556 Elm Street
Chester, VT 05143

Request To Amend Protected Health Information Records

The individual for whom the amendment is being requested:

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ E-mail: _____

Please specify the records you wish to amend: (Include date/s of service and reasons for amendment.
Attach additional pages as needed)

Please list the names and addresses of the individuals or companies to notify should we agree to make the amendment.

Signature: _____ Date: _____
(Individual or Personal Representative)

If signed by a Personal Representative, please complete the following:

Representatives Name: _____ Relation: _____

Representative's Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ E-mail: _____

Send this form along with any attachments to our Privacy Officer at the address above.

April 2003

