PATIENT REQUEST TO AMEND HEALTH INFORMATION RECORDS

As a Patient of Pulse Medical Transportation, you have the right to ask us to amend protected health information that we maintain about you. Requests for amendments to your PHI should be made using this form and should be mailed to Pulse Medical Transportation at our information below.

Patient Name: _____ **Date of Birth**: _____ / _____ / _____

Patient Address: _____

Run Number: _____ **Date of Transport:** _____

The person named above has been a Patient of:

PLMD, LLC
d/b/a Pulse Medical Transportation
10715 Red Run Blvd, Suite 110
Owings Mills, Maryland 21117

I am requesting the following change be made to my Health Information:

_____

_____

_____

_____

Purpose of change request:

_____

_____

_____

_____

I understand that PLMD, LLC d/b/a Pulse Medical Transportation reserves the right to deny requests for amendment of health care records. Should the request be approved, Pulse Medical Transportation will retain the original health care information as part of the Patient's permanent medical record.

The request must be submitted in writing and mailed to 10715 Red Run Blvd, Suite 110, Owings Mills, MD 21117 or faxed to 443-501-3950.

Please note, to change demographic information (name, date of birth, address, etc.), you do not need to use this form. You may request the change by sending us a written request by fax or mail (see above).

AUTHORIZATION:

Printed name of Patient or Authorized Representative: _____

_____ _____
Signature of Patient or Authorized Representative **Date**

If not signed by the Patient, indicated relationship of authorizing person to Patient:

- ☐ Parent or Guardian of minor child
- ☐ Guardian, Spouse or conservator of conserved Patient
- ☐ POA, Beneficiary, Spouse or personal representative of a deceased Patient

If your request is accepted and the appropriate amendment is made, a copy of the amended information will be sent to anyone who has previously received this information. If there is anyone else you would like to receive this amendment, please write the name(s) and address(es) of the organization(s) or person(s):

Name_____
Address_____
Name_____
Address_____
Name_____
Address_____

This form is to be mailed to:

PLMD, LLC
d/b/a Pulse Medical Transportation
Attn: HIPAA Compliance Officer
10715 Red Run Blvd, Suite 110
Owings Mills, Maryland 21117