**JACKSON TOWNSHIP EMERGENCY MEDICAL SERVICES**
**REQUEST TO AMEND PROTECTED HEALTH INFORMATION**

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Date: _____

Address: _____
Street City State Zip Code

1. Please describe what protected health information (PHI) that you want to change, and include the reasons to support your request:

_____

_____

2. If we decide to change the health information as requested, we will send the change to any person or organization that received the information before it was changed. Please provide those name(s) and address (es), if applicable.

Please note that Jackson Township EMS cannot amend your PHI if:

- The information is accurate and complete
- You do not have the legal right to access the PHI you want changed
- We did not create the information, unless the covered entity that created the information is unavailable to act on your request to change it (if this is the case, please explain)
- The information you want changed is not part of your Designated Record Set (medical record, billing record and information used to make decisions about you).

Jackson Township Emergency Medical Services may accept or deny your request to amend as permitted under law. If denied, you will be informed in writing of the reason for the denial and what you should do if you disagree with the denial. You will be notified whether your request is accepted or denied within 60 days of receipt of this request. Jackson Township EMS can extend the response period for up to an additional 30 days by notifying you in writing.

***A copy of this form is valid as an original***

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____
Date Received by Jackson Twp. EMS

**Forward Request to:**
**Jackson Township Emergency Medical Services**
**ATTN: Privacy Officer**
**P.O. BOX 516**
**Jackson, NJ 08527**
**Compliance@jtfas.org**

**IDENTIFYING INFORMATION**

☐ COPY OF IDENTIFICATION ATTACHED

TYPE ATTACHED_____

(VALID STATE ISSUED DRIVER'S LICENSE, VALID STATE ISSUED IDENTIFICATION CARD, BIRTH CERTIFICATE, ANY OTHER VALID GOVERNMENT ISSUED PHOTO IDENTIFICATION)

**IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

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**NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC**

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**PERSONAL REPRESENTATIVE INFORMATION**

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**WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE MEDICAL DECISIONS FOR THE PATIENT**

☐ **PARENT**

☐ **GUARDIAN**

☐ **CONSERVATOR**

☐ **MEDICAL POWER OF ATTORNEY**

☐ **EXECUTOR OF WILL**

☐ **OTHER** _____

**NOTE:** ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIUDAL.