Medical Record Amendment Request

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

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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 DEPARTMENT USE ONLY

Paid $_____ CHECK #_____

☐ APPROVED FOR RELEASE

☐ NO RECORDS FOUND

☐ RECORD ENCLOSED

☐ RELEASED DATE/BY: _____

_____

SIGNATURE AND DATE

Fire and Rescue Department

Mail 240 S. First Avenue, Hillsboro, Oregon 97123 Phone 503.681.6166 Fax 503.681.6208

Web www.ci.Hillsboro.or.us/fire

HILLSBORO EST. 1881 FIRE & RESCUE