



368-A Jesse Street  
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**24 Hour Dispatch Line:**  
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### Amendment of Protected Health Information (PHI) Request

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### Information to Amend:

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

Name  Marital Status  
 Billing Address  Surrogate Decision Maker  
 Mailing Address  Organ Donor  
 Current Medical Condition  Other: Please describe \_\_\_\_\_  
 Past Medical History \_\_\_\_\_  
 Current Medications \_\_\_\_\_  
 Allergies \_\_\_\_\_

Please specifically describe what information you wanted amended. Please **ONLY** list the new information. Attach a separate sheet if necessary.

DocRide, in its capacity as a non-emergency medical transportation provider, is entitled to perform and bill for services based on all protected health information in its current form or upon which it has already relied until such time as the amended information becomes effective. DocRide is not required to accept your request for amendment and will notify you in writing as to the decision on your request.

Your signature below indicates that you have agreed to accept these terms as they have been listed and to provide payment, if required, to DocRide based on existing protected information until such time that the amendments you have made are effective.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_