Mutual Aid Ambulance

Patient Request for Access From

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____

Date(s) of Service: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or *PHI,* in accordance with federal law. You may also have the right to request an amendment to your *PHI*, or request that we restrict the use and disclosure of *PHI.* These rights are further described in Mutual Aid Ambulance Services Notice of Privacy Practices and in other policies you may have upon request.

To better allow us to process your request, please indicate the type of request you are making on this form: [Check all that apply]

_____ Access to simply review my health information.

_____ Access to obtain copies of my health information.

_____ Access to review and potentially request an amendment to my health information.

_____ Access to review and potentially request an accounting of how my PHI has been disclosed to others.

_____ Access to review and potentially request restrictions on the use and disclosure of my health information.

*Signature:*_____ *Request Date:* _____