## Mutual Aid Ambulance

## Patient Request for Access From

Patient Name:		Date:	
Address:			
City:	State:	Zip Code:	
Social Security Nu	mber:		
Date(s) of Service:			
protected health in have the right to re use and disclosure	nformation, or <i>PHI</i> , in accordance an amendment to ye of <i>PHI</i> . These rights are	ht to access, copy or inspect your ordance with federal law. You may also your <i>PHI</i> , or request that we restrict the further described in Mutual Aid ices and in other policies you may have	
	to process your request, ; form: [Check all that app	please indicate the type of request you bly]	
Access to sir	mply review my health inf	formation.	
Access to ob	tain copies of my health i	nformation.	
Access to re information.	view and potentially requ	est an amendment to my health	
Access to rebeen disclosed to	• • •	est an accounting of how my PHI has	
Access to re of my health inforr	• • •	est restrictions on the use and disclosure	
Signature:		Request Date:	