

# **Bangs Ambulance**

## **Patient Request for Records Access Form**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Records for Date of Service: \_\_\_\_\_

\_\_\_\_\_ Verification of patient's Identity(government issued photo ID) – attach copy

\_\_\_\_\_ Verification of patient's personal representative's Identity (government issued photo ID and copy of documents giving authority) – attach copy

*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 it. These rights are further described in our Notice of Privacy Practices and in other policies which 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 and obtain a copy of my Prehospital Care Report

\_\_\_\_\_ Access to simply review/obtain copies of all PHI for date of service

\_\_\_\_\_ Access to obtain copies of all of my PHI

\_\_\_\_\_ Access to review and potentially request amendment of my PHI

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

\_\_\_\_\_ Access to review and potentially request restrictions on the use and disclosure of my PHI

*Signature* \_\_\_\_\_ *Request Date* \_\_\_\_\_