League City Volunteer EMS (LCVEMS)

Patient Request for Access Form

To provide written authorization for the use or disclosure of PHI that is NOT related to treatment, payment or operations.

Patient Name: _____ Date: _____

Address: _____

City: _____State: _____ Zip Code: _____

Social Security No.: _____Date 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 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 my health information.

_____ Access to obtain copies of my health information.

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

_____ 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 health information.

Signature _____ *Request Date* _____

Please attach a copy of a valid photo ID such as a Drivers License or Passport

Received Date _____

Reviewed By _____

Date sent to Patient _____