

## WILLARD FIRE & RESCUE Patient Request for Access to Protected Health Information

Address:  City:  State:  Zip:  Home Phone:  Email:  **** Photo ID Must Be Presented For Verification by Requester or Authorized Representative  ****  Copy of Driver's License or Photo ID card  Copy of Driver's License or Photo ID card  Copy of Driver's License or Photo ID card  Right to Request Access to Your PHI and Our Duties:  You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, the you also have a right to obtain a copy of that information electronically. In addition, you may request that we transmit a copy of your PHI directly to another person and we will honor that request when required by law to do Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.  Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your PHI within thirty (30) day	FIRE & RESCUE			1	Т	
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to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, le authority to act on behalf of the patient (such as a power of attorney) or other information necessary to verify the requestor has the right to access PHI. In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you accesyour PHI, subject to the limits of applicable state law.  **Request for Access to PHI:**  Below, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dat of service and other details that will allow WILLARD FIRE & RESCUE to accurately and completely fulfill your requesting access.	You (or your authorized representative) had information ("PHI") that we maintain in a dyou also have a right to obtain a copy of the transmit a copy of your PHI directly to ano Requests to transmit PHI to another party identify the designated person to whom the Generally, we will provide you (or your authority to act on behalf of the patient (so the requestor has the right to access PHI. may appeal certain types of denials. We may our PHI, subject to the limits of applicable Request for Access to PHI:  Below, please describe the PHI that you ar	ave the right to income designated record nat information eleather person and variety must be in writing the PHI should be stated as a power of a limited circums nay also charge your state law.	spect or obtain a coll set. If we maintally. In accept we will honor that g, signed by you (dent, and where the tative) access to PH the patient's sociattorney) or other stances, we may do u a reasonable collections.	copy of your pain your PHI in dition, you no request when or your represe PHI should four PHI with all security not information eny you accept-based feeth specificity at the specificity and the specificity	protection election requirements sentiated to be sentiated to	eted health tronic format, then quest that we dired by law to do so cive), and clearly nt.  ty (30) days of your chority of the persor r, date of birth, legal ssary to verify that your PHI, and you oviding you access to

## Please check all that apply and fill out the requested information, where indicated. Please provide me with a copy of my PHI **Mail.** Please send a copy of my PHI to me at the following address: City: State: Zip Code: Format (paper copy, digital copy on a disc, etc.): **Email.** Please email a copy of my PHI to the following email address in the specified format: Email address: Format (PDF): Please transmit a copy of my PHI to the following party at the following mailing address or email address in the specified format: Designated Party: Street: City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ Email address: Format (Paper, PDF, etc.): I would like to inspect a copy of my PHI at WILLARD FIRE & RESCUE's place of business (WILLARD FIRE & RESCUE will arrange a convenient time and place for you to inspect a copy of your PHI during normal business hours) Signature of Requestor: Request Date: Requestor Information (if requestor is different from patient): First: MI: DOB: Last: Address: City: State: Zip: Cell Phone: Home Phone: Relationship: Email: Examples: Parent, Legal Guardian, etc.

Specify How You Would Like us to Provide Access: