**NATIONAL AMBULANCE**
**Patient Request for Access to PHI Form**

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Last 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 indicated 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:* _____

**Valid photo Identification will be needed to confirm identity.**

*Identification Verified By:* _____