PHYSICIANS AMBULANCE SERVICE, INC

Patient Request for Access to Protected Health Information

Patient's Full Name _____ Date of Birth _____

Patient's Address _____ Zip _____

City _____ State _____ Phone Number _____

Email _____

Patient 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, then 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 so. 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 days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as power of attorney), or other information necessary to verify that 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 access to your PHI, subject to the limits of applicable state law.

Request for Access to PHI:
Below, describe the PHI that you are requesting access to with as much detail as possible. Provide specific dates of service and other details to allow us to completely fulfill your request.

_____

_____

How would you like to receive your records:

☐ Paper via the address listed above ☐ Email via the email listed above

☐ Review in person at our billing office: 6670 W Snowville Rd Ste 2, Brecksville, OH 44141 - this is by appointment only during business hours

☐ I give permission for my PHI to be sent to the following party ☐ via paper at the address listed below ☐ via email at the email listed below

Full name _____ Relationship to Patient _____

Street Address _____

City, State, and Zip Code _____

Phone Number _____

Email Address if sending via email _____

**If you select the email option, you hereby acknowledge and accept the inherent risk associated with an unsecured email transmission, which can place your information at risk of being read or accessed by someone else, and you agree that Physicians Ambulance Service, Inc will not be responsible for the disclosures that might occur in transit.*

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive this patient's health information.

Signature of Requestor _____ Request Date _____

Requestor Information (if different from patient)

Name _____ Relationship to Patient _____

Street Address _____ Phone Number _____

City _____ State _____ Zip _____

Complete form and send to:
6670 W Snowville Rd, Ste 2
Brecksville, OH 44141
or via email to patientaccounting@physiciansambulance.com