Pinellas County EMS/Sunstar
Request for Access to Protected Health Information

Patient Name:________________________________Phone:_____________________

Street Address: ____

City:____________________________State:_______________Zip Code: ___________

Email:_________________________________Date of Birth: _______________________

Last 4-digits of SSN: ________________

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 (30) 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 a 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:

On the following page, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dates of service and other details that will allow Pinellas County EMS/Sunstar to accurately and completely fulfill your request.

Patient Care Report (Medical Record): ___ Date(s) of Service: _______________

____

Invoice: ___ Date(s) of Service: _______________

____

Additional details:

____

Relationship to Patient

Please check option which applies:

_____ I am the patient

_____ I am the parent/guardian of a minor; Relation: _______

Signature of Requestor: ________________________________ ***Request Date:*** __________

Name of Signatory (Legibly Printed or Typed): ____

Date: _______________________

Requestor Information (if requestor is different from patient):

Name: _____________________________________

Street Address: ____

City: _____________________________ State: _______________ Zip Code: ___________

Phone Number: ________________________