

Request for PHI - Patient

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: _____

Was the Patient Transported?: (Y/N) _____

Invoice: _____

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 Requester: _____ ***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: _____