Washington County Emergency Medical Services

"SERVING WASHINGTON COUNTY SINCE 1979"

Patient Request for Access Form / HIPAA

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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 indicate 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 account 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 of Patient, Parent, or Guardian: Printed Name: Date:

X _____ _____ _____

Relation (If not patient): _____

Provider Signature: Printed Name: Date:

X_____ _____ _____

IF THE ABOVE SIGNATURE IS NOT WITNESSED BY "THE PROVIDER", IT MUST BE NOTORIZED BELOW

I, _____, a Notary Public in and for the State of _____, do hereby certify that the above signature was witnessed, by myself and that the above information was sworn before me to be correct & accurate. I further certify that the identification of the signor was verified by photo ID.

Given under my hand and seal of office on this _____ day of _____, 20___.

_____
Notary Public in and for the State of _____

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