Wilton Volunteer Ambulance Corps
Patient Request for Access to Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Date of Birth: _____

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. 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:

Below, 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 Wilton Volunteer Ambulance Corps to accurately and completely fulfill your request.

_____

_____

_____

Specify How You Would Like us to Provide Access:

Please check all that apply and fill out the requested information, where indicated.

____ Please provide me with a copy of my PHI

Please send a copy of my PHI to me at the following address:

Street: _____

City: _____State:_____ Zip Code: _____

____ Please provide a copy of my PHI to the following party at the following mailing address:

Designated Party: _____

Street: _____

City: _____State:_____ Zip Code: _____

Signature of Requestor: _____ ***Request Date:*** _____

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____