

MOBILE MEDICAL RESPONSE, INC.
REQUEST FOR ACCESS TO PHI



The undersigned individual hereby requests access to his/her protected health information (PHI) or is the legally authorized representative for the patient, contained in a designated record set, as follows:

Patient Name: _____ Date of Service: _____
Date of Birth: _____ SSN: _____ Location of call: _____

The request is to:

- See the record or records Receive a copy of record or records
There is a small charge to cover the costs of copying run reports.

Reports will be:

- Picked up (phone#: _____) Faxed: _____
 Mailed: _____

IDENTIFICATION OF PATIENT ASCERTAINED BY: *Requires two separate documents for verification)*

ID Card (Pictured): _____ State issued: _____ Expiration Date: _____

Drivers License # _____ Expiration Date: _____ State issued: _____

Social Security Card: _____ Other Identification: _____
Describe

Signature: _____ Date: _____

**Please have your signature witnessed and notarized if you are mailing or faxing this form.*

On this ____ day of _____, 20____, personally appeared _____
Patient or legally authorized representative for _____
_____, Notary, _____ County

Action taken in response to the forgoing request:

SEAL

- Accepted in Full

If partially accepted, state the part that is accepted: _____

If partially or wholly denied, state the reasons: _____

Date signed: _____

Signed by: _____

Title: _____