



Cumberland Rescue Service

Patient Request for Access to Protected Health Information

Patient Name: _____ Date: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Social Security No. (Last Four Digits: _____

D.O.B. _____

Last Date of Service: ____/____/____

Patients Rights: As a patient, you have the right to access, copy, or inspect your protected health information, or PHI as allowed by federal law. You may also have the right to request that an amendment to you 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 in 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 an accounting 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: _____ Request Date: ____/____/____

Proof of Identification (attach a copy to the request)

Reviewed by: _____

Privacy Officer