



**Westerly Ambulance Corps, Inc.
Patient Request for Access of PHI Form**

Patient Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

S.S. Number: _____ **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 that 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 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:** _____

ID Verified By: ☐ Driver's License ☐ Other Photo ID ☐ Other: _____

Verifier: _____ **Date Given:** _____