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Evergreen Fire Protection District
Ambulance Patient
Request for Access Form

All fields are required:

Patient Name: _____ Date: _____

Street Address/P.O. Box: _____

City: _____ State: _____ Zip Code: _____ - _____

Social Security No: _____ 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 allow us to process your request in a timely manner, please indicate the type of request you are making by checking/clicking all applicable boxes below:

- ☐ Access to 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: _____

SIGNATURE REQUIRED: If form will be submitted online, an electronic signature is required. If form will be printed and returned in hard copy form, then a written signature is required.