

Hartford HealthCare 
Emergency Medical Services
HUNTER'S AMBULANCE

HUNTER'S AMBULANCE SERVICE, INC.

Patient Request for Access Form

Patient Name: **Date:**

Name of Requestor, if other than Patient:

Address:

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

Patient Social Security Number:

Date of Service:

PATIENT RIGHTS:

As a patient, you have the right to access, copy or inspect your PHI information 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 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 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: