PENFIELD VOLUNTEER EMERGENCY AMBULANCE SERVICE, INC.

BUSINESS PHONE: 872-6060
FAX #: 872-2105

THE PENFIELD VOLUNTEER EMERGENCY AMBULANCE SERVICE, INC.
P.O. BOX 220 • 1585 JACKSON ROAD • PENFIELD, NEW YORK 14526

Patient Request for Access to Protected Health Information

Patient Name: _____

Patient Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Your Right to Request Access to Your PHI and Our Duties:

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have a right to obtain a copy of that information electronically. In addition, you may request that we transmit a copy of your PHI directly to another person and we will honor that request when required by law to do so. Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.

Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as a power of attorney) or other information necessary to verify that the requestor has the right to access PHI. In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

Request for Access to PHI:

Below, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dates of service and other details that will allow Penfield Ambulance to accurately and completely fulfill your request.

_____

_____

_____

_____

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Specify How You Would Like us to Provide Access:
Please check all that apply and fill out the requested information, where indicated.

____ Please provide me with a copy of my PHI

____ **Mail.**

Please send a copy of my PHI to me at the following address:
Street: _____
City: _____State: _____ Zip Code: _____

____ **Email.**

Please email a copy of my PHI to the following email address in the specified format:
Email address: _____
Format (PDF, Word, etc.): _____

____ Please transmit a copy of my PHI to the following party at the following mailing address or email address in the specified format:

Designated Party: _____
Street: _____
City: _____State:_____ Zip Code: _____
Email address: _____
Format (Paper, PDF, Word, etc.):_____

____ I would like to inspect a copy of my PHI at Penfield Ambulance's place of business (Penfield Ambulance will arrange a convenient time and place for you to inspect a copy of your PHI during normal business hours)

Signature of Requestor:

X_____ **Request Date:** _____

Requestor Information (if requestor is different from patient):
Name: _____
Relationship to Patient (parent, legal guardian, etc.):_____
Street Address: _____
City: _____State: _____ Zip Code: _____