Forsyth County Emergency Services
Patient Request for Access Form

Patient Name: ___________________________ Date: ________________

Address: ____

City: _____________________________ State: _____ Zip Code: _____________

Social Security No.: XXX-XX-_______ DOB: ________________

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 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.

___ Release of my information or medical record to a third party listed as ___

Patient Signature ______________________________________ Request Date ___/___/______

For Office Use Only: (Official Seal)

Date Received in FCEMS Office ___/___/____ Date Received by Privacy Officer ___/___/____

Date of Response to Requestor ___/___/____ Compliance/Privacy Officer _________________