Trinidad Ambulance District
939 Robinson Avenue
Trinidad, CO 81082
Office: (719) 846-6886
Fax: (719) 846-8431

Patient Request for Access to Protected Health Information (PHI)

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. ***A notarized signature on this document or government issued ID presented by signatory at our office is required to verify the identity of any person who requests access to PHI.*** We may also verify 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 copies of your requested PHI documents.***

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 (DOS) and other details that will allow Trinidad Ambulance District to accurately and completely fulfill your request.

Patient Name: _____

Date of Birth: _____ Social Security: _____-_____-_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Proof of Identification Presented: □Driver License □ State ID □Other_____

Requestor of Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Signature of Requestor: _____ Request Date: _____

I, _____, authorize
(Print Patient or Patient's Parent/Legal Guardian. Other than patient must provide proof of legal authority)
_____ to act on my behalf in
(Designated Representative)
requesting and obtaining my personal health information from Trinidad Ambulance District as described on the previous pages.

_____ _____
(Patient or Legal Guardian Signature - Other than patient must provide proof of legal authority) *Date*

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20___ , before me a notary public, the undersigned personally appeared _____ and has
(name of patient or legal guardian)
satisfactorily proven to me to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

_____
NOTARY PUBLIC

(SEAL)

My Commission Expires: _____

Specify Information Requested

Date(s) of Service: _____

_____ Billing Records

_____ Medical Records

_____ Other (specify): _____

Specify How You Would Like us to Provide the Requested Information

Please check all that apply and fill out the requested information, where indicated.

____ **Certified Mail.**

Designated Representative: _____

Street: _____

City: _____State:_____ Zip Code: _____

____ **Email address:** _____

____ **Fax Number:** _____ **Attention To:** _____

____ **Office Pick Up.** Please contact Trinidad Ambulance District to arrange a convenient time and place for you or your designated representative to collect your PHI during normal business hours)