# *Request for Access to PHI*

The undersigned individual hereby requests access to his/her protected health information (PHI) or is the legally authorized representative for the patient, contained in a designated record set, as follows:

Patient Name: ______________________________ Date(s) of Service: _______________

Date of Birth: _____________ SSN: xxx-xx-_______ Phone Number: ________________

**The request is to:**

☐Receive a copy of the record or records

**Records will be:**

☐Emailed: __________________________________________________________

☐Mailed: _________________________________________________________

☐Faxed: _________________________________________________________

☐Picked Up (Copy of driver's license required)

**Signature* _________________________________________________

*Date* ___________________________________

****Please have your signature notarized if mailing, faxing or emailing form.***

****If you are signing on behalf of the patient, supporting documentation must be submitted along with the signed form (i.e. power of attorney paperwork, personal representative paperwork, and/or death certificate if applicable.***

On this _____ day of _____________, 2020, personally appeared________________________

Patient or legally authorized representative for _______________________________________,

Notary______________________________, _________________ County

STAMP

Mobile Medical Response, Inc.
834 S. Washington Ave.
Saginaw, MI 48601
Fax (989)399-7842