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 date, _____ , personally appeared _____

Patient or legally authorized representative for _____,

Notary_____, _____ County

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

STAMP