CETRONIA AMBULANCE CORPS, INC.

Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Last Date of Service: _____

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.

__X__ 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.

1. I hereby authorize CETRONIA AMBULANCE CORPS, INC. ("Cetronia") to provide access to my protected health information and send copies of all treatment and billing records regarding medical services Cetronia provided to me in _____[month/year]

2. I authorize Cetronia to disclose the following items: letters, e-mails, treatment notes, charts, studies, reports, and similar documents.

3. I hereby authorize Cetronia to disclose my protected health information to the following person(s):

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHEFIELD, MI 48086 - 5054

P: 248.357.3330
F: 248.357.3337

4. I make this request for the following purposes:

FOR DISCOVERY BEFORE TRIAL

[statement of reason for request]

5. The authority provided by this authorization expires on _____, 20____.

Patient Rights

1. 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.

2. You have the right to revoke the authorization set forth below by sending us a ***written*** request. Any exceptions to that right will be found in Cetronia'a Privacy Policies.

3. Cetronia is not permitted to condition the provision of its services or your eligibility for benefits on your agreement to sign this authorization.

4. Please be aware that information disclosed pursuant to this authorization could be re-disclosed by someone other than Cetronia and therefore no longer subject to privacy protection.

If Requested by Someone Other than Patient

_____ I, _____, hereby certify that I have been appointed to serve as the personal representative for the estate of _____ [deceased] and am authorized to request protected health information on behalf of that patient's estate. I attach copies of relevant documentation to this Request.

_____ I, _____, hereby certify that I hold a valid power of attorney for _____ [name of patient] and attach a copy of that document to this Request.

_____ I, _____, hereby certify that _____ [name of patient] is a minor and that I am the parent or legal guardian of that person.

Signature _____ *Request Date* _____