MOBILE MEDICAL RESPONSE, INC.
REQUEST FOR ACCESS TO PHI

MMR
MOBILE MEDICAL RESPONSE, INC.

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 of Service:**_____
Date of Birth: _____**SSN: XXX-XX-**_____ **Location of call:**_____
Phone Number:_____

The request is to:

☐ See the record or records ☒ Receive a copy of record or records
There is a small charge to cover the costs of copying run reports.

Reports will be:

☐ Picked up (phone#:_____) ☒ Faxed: 248.357.3337

- OR - ☒ Mailed: **RECORDS DEPOSITION SERVICE, INC.**
PO BOX 5054 **P: 248.357.3330**
SOUTHFIELD, MI 48086 - 5054 **F: 248.357.3337**

IDENTIFICATION OF PATIENT ASCERTAINED BY: *Requires two separate documents for verification)*

ID Card (Pictured):_____ State issued:_____ Expiration Date:_____

Drivers License #_____ Expiration Date:_____ State issued:_____

Social Security Card:_____ Other Identification:_____
Describe

Signature: _____ Date:_____

Please have your signature witnessed and notarized if you are mailing or faxing this form.

On this ____ day of _____, 20___, personally appeared _____
Patient or legally authorized representative for_____
_____, Notary, _____County

Action taken in response to the forgoing request: SEAL

☐ Accepted in Full

If partially accepted, state the part that is accepted: _____

If partially or wholly denied, state the reasons: _____

Date signed: _____ MMR Rep: _____

Title: _____

Mobile Medical Response, Inc.
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989-758-2900