MOBILE MEDICAL RESPONSE, INC.
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 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: **248.357.3330**

\- OR - ☒ Mailed: **RECORDS DEPOSITION SERVICE, INC.**
PO BOX 5054
SOUTHFIELD, MI 48086 - 5054

P: 248.357.3330
F: 248.357.3337

<u>IDENTIFICATION OF PATIENT ASCERTAINED BY</u>: ***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.
834 S. Washington
Saginaw, Michigan 48601
989-758-2900