KAUKAUNA AMBULANCE SERVICE

Patient Request for Access Form

Patient Name (please print)_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Social Security No.:_____

Last Date of Service:_____

Patient Rights: 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.

To better allow us to process your request, please indicate the type of request you are making on this form: [check all the apply]

_____Access to simply review my health information.

_____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.

Signature_____ Request Date_____

Please Return the completed form to:

Kaukauna Rescue Service
Attn: Medical Records
201 W 2nd Street
Kaukauna, WI 54130