MONROE AMBULANCE

1669 Lyell Ave
Rochester NY 14606-2311

PATIENT'S REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient's Name:____

I request that Monroe Ambulance provide me with access to my Protected Health Information as described below:

Information Requested {Please describe}

1.____

2.____

3.____

4.____

This information covers the dates _______________through_________________.{Please fill in dates}

Type of Access Requested {Check all that apply}

1. ☐ Copies of requested information

I understand that Monroe Medi-Trans Inc. dba Monroe Ambulance may charge a fee for the costs of copying, mailing or other supplies. Our fee for copying is $.75 per page plus postage.

2. ☐ Inspection of my health information at the facility.

Please Contact ___________________________to arrange a mutually convenient time for inspection.

3. ☐ A summary of my health information.

4. ☐ An explanation of my health information.

If you are requesting a copy, summary or explanation of the information, how would you like the information delivered to you?

BY MAIL:___________________________ BY EMAIL:_____________________________

Address:______________________________ Address:________________________________

_____________________________________ ____

SIGNATURE

I have read, understand the terms of, and have had an opportunity to ask questions about this Request.

Signature of Patient or Personal Representative:____

Print Name of Patient or Personal Representative:_______________________________________

Description of Personal Representative's Authority:_____________________________________

Date:______________________________________

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address: ____

____

____

Telephone:____________________________[Daytime] _________________________[Evening]

For Monroe Ambulance Use Only

Date Monroe Ambulance Request Received:____

Monroe Ambulance Decision of Request: ☐ Accepted ☐ Denied

Date Patient Given Written Notice of Decision:____

Patient Requests Initial Review: ☐ Yes ☐ No

Date of Request:____

Date Patient Given Written Decision of Initial Reviewer:___________________________________

Name and Title of Person Handling this Request:____

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