Pinellas County EMS/Sunstar
Request for Access to Protected Health Information

Patient Name:_____ Phone:_____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Email:_____ Date of Birth: _____

Last 4-digits of SSN: _____

Right to Request Access to Your PHI and Our Duties:

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have a right to obtain a copy of that information electronically. In addition, you may request that we transmit a copy of your PHI directly to another person and we will honor that request when required by law to do so. Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.

Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as a power of attorney) or other information necessary to verify that the requestor has the right to access PHI. In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

Request for Access to PHI:

On the following page, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dates of service and other details that will allow Pinellas County EMS/Sunstar to accurately and completely fulfill your request.

Patient Care Report (Medical Record): ___ Date(s) of Service: _____

_____

Invoice: ___ Date(s) of Service: _____

_____

Additional details:

_____

Specify How You Would Like us to Provide Access:

Please check all that apply and fill out the requested information, where indicated.

____ **Mail.** Please send a copy of the PHI to me at the following address:

Street: _____

City:_____State:_____Zip Code: _____

Format (paper copy, digital copy on a disc):

_____

_____

****Email.** Please email a copy of the PHI to the following email address. (Format is in PDF only):

Email address: _____

****Please be advised that all government email correspondence is subject to public record**

____ Please transmit a copy of the PHI to the following party at the following mailing address or email address in the specified format:

Designated Party: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Format (Paper, PDF, etc.): _____

____ I would like to review a copy of the PHI at Pinellas County EMS/Sunstar's place of business (Pinellas County EMS/Sunstar will arrange a convenient time and place for you to review a copy of the PHI during normal business hours)

Relationship to Patient

Please check all that apply **(options continue on next page):**

Patient Living and Legally Competent

_____ I am related to the patient (**HIPAA Authorization from patient required**); Relation: _____
(Spouse, Adult Child, Parent, etc.)

Patient Living and Not Legally Competent

_____ I am the Power of Attorney (POA) with Health Care Surrogacy (**Attach Supporting documents)**

_____ Patient has been declared incompetent and I am a Court Appointed Legal Guardian (**Attach Supporting Court Documents**)

Patient is Deceased (Copy of Death Certificate Required)

_____ I am the Personal Representative of the Estate (**Attach Supporting Probate Court documents**)

_____ ****I am the next of kin & there is "No" Estate; Relation: _____
(Spouse, Adult Child, Parent, etc.)

****If you are the next of kin and there is "No" Estate, please provide documentation of your involvement in the decedent's care or payment for treatment of care prior to the decedent's passing.**

_____

_____

_____

_____

Signature of Requestor: _____ ***Request Date:*** _____

Name of Signatory (Legibly Printed or Typed):_____

Date: _____

Requestor Information:

Name: _____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Phone Number:_____