SABLE-ALTURA FIRE PROTECTION DISTRICT

Request for Access to Protected Health Information

Patient Name:_____ Date:_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Home Phone:_____ Date of Birth:_____

Social Security Number:_____-_____-_____

Last Date of Service:_____

Your Rights as a Patient:

As a patient, you have the right to access, copy or inspect your protected health information in accordance with Federal and State law. You also may have the right to request an amendment to your protected health information, or request that the District restrict the use and disclosure of your protected health information. These rights are further described in the District's Policy on Patient Access, Amendment and Restriction on Use of Protected Health Information, a copy of which will be given to you upon request.

To assist in processing your request, please indicate the type of request you are making (Check all that apply):

_____ Access to review my protected health information only.

_____ Access to obtain copies of my protected health information.

_____ Access to review and possibly request amendment of my protected health information.

_____ Access to review and possibly request an accounting of how my protected health information has been used and disclosed to others.

_____ Access to review and possibly request restrictions on the use and disclosure of my protected health information.

Patient Signature_____ Date:_____