LifeCare Ambulance Medical Services
Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City:._____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years prior to the date of the request from LCA, to amend your PHI and to request restrictions on the uses and disclosures of your PHI. I understand that LCA has the right to deny access to portions of your PHI if one of the following conditions are met:

1. The information you requested was compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;(Not appealable)

2. The information you requested was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.(Not appealable)

3. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;(Appealable)

4. The protected health information makes reference to another person (other than a health care provider) and a licensed health professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to that person;(Appealable)

5. The request for access is made by you as a personal representative of the individual about whom you are requesting the information, and a licensed health professional has determined, in the exercise of professional judgment, that access by you is reasonably likely to cause harm to the individual or another person.(Appealable)

Signature _____ Request Date _____