

**San Diego Medical Services  
Patient Request for Access Form**

**Patient Name:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Incident Street Location or Run #:** FS

**Patient Rights:** As a patient, you have the right to access, copy or inspect your protected health information (PHI), in accordance with federal and state laws, rules and regulations. 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.

To better allow us to process your request, please indicate the type of request you are making on this form: [check all that 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*You must provide a photocopy of a legal ID listed in Section 1 and return with the completed form.

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*Office Use Only*

<b>Section 1</b>			
Type of Photo ID Viewed	_____	Driver's License/State ID	_____
	_____	Other Photo ID	_____
		Military ID	_____
		Passport	_____

Update to Patient Accounting Log      \_\_\_\_\_ Yes      \_\_\_\_\_ No      \_\_\_\_\_ N/A

List of Patient Information/Documentation Released and Purpose:

\_\_\_\_\_