

## San Diego Medical Services Patient Representative Request for Access Form

I understand that it is the policy of Rural/Metro Corporation to keep all patient records and patient information confidential. In addition, I understand that Rural/Metro Corporation is providing patient information to me as required by state law or because I have produced legal documentation giving me the ability to receive such information. I attest that any documentation I have provided to Rural/Metro, giving me the authority to receive the requested patient information, is a legally operative and effective document. Rural/Metro Corporation will not be held responsible for any defects in the legal document that may render it inoperative.

<b>Requestor:</b> _____	<b>Date of Request:</b> _____
<b>Signature:</b> _____	
<b>Title (if applicable):</b> _____	<b>Relationship to Patient:</b> _____
<b>Telephone:</b> _____	<b>Address of Requestor:</b> _____
<b>Name of Patient::</b> _____	<b>Date of Service:</b> FS _____

Please indicate the type of request you are making on behalf of the patient: [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.

\*To receive the requested PHI on behalf of the patient, the requestor must provide, with this access form, a copy of one legal document listed in Section 1 and a copy of a legal ID listed in Section 2.

### Office Use Only

<b>Section 1</b>	
Copy of legal document attached	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of legal document attached	<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Patient Written Authorization <input type="checkbox"/> Estate/Executor Document <input type="checkbox"/> Other: _____

<b>Section 2</b>	
Type of Photo ID Viewed	<input type="checkbox"/> Driver's License/State ID <input type="checkbox"/> Military ID <input type="checkbox"/> Other Photo ID _____ <input type="checkbox"/> Passport

Update to Patient Accounting Log       Yes       No       N/A

List of Patient Information/Documentation Released and Purpose:

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