

Stockton Fire Department
Patient Request for Access Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Last Date of Service: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your Protected Health Information, or PHI, in accordance with federal law. 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 and in other policies, which you may have upon request.

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

At the time of collection of the PHI, you must provide a government-issued photo identification matching the personal information listed on the PHI.

- 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.

Personal Representative: If you are not the patient but a personal representative of the patient, please provide your:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please indicate your relation to the patient and provide the following documentation:

Stockton Fire Department
Patient Request for Access Form (cont'd)

- Parent or guardian of a minor patient. Provide proof of parental or guardian relationship. E.g., birth certificate naming the personal representative as a parent.
- Guardian or conservator of an adult patient. Provide proof of guardian or conservator relationship. E.g., a court-issued document confirming your appointment.
- Agent pursuant to a power of attorney for health care decisions (inapplicable for deceased patients). Provide a document designating you as the agent. E.g., Advance Health Care Directive form.
- (Only for deceased patients) Executor or Administrator of the patient's estate. Provide a court document showing your appointment as executor or Administrator.
- (Only for deceased patients) Beneficiary of the patient. Provide a court document showing your status as a beneficiary. E.g., a probate court order certifying a will in which you are named or a court-approved spousal property petition. Alternatively, submit a properly executed Affidavit for Collection of Personal Property if the deceased patient had no will and a small estate.

Signature: _____ Request Date: _____