Larkspur Fire Protection District

Patient PHI Access Request Form / Authorization to Disclose Health Information Form

Patient Legal Name: ____

Date of Birth: ________________________ Telephone Number: ____________________________________

Street Address: ____

City: _____________________________________ State: _______ Zip: ____________________

Social Security Number: ____________________________________

Last Date of Service: ______________________________________

Patient Rights: In accordance with federal law you, as a patient, have the right to access, copy or inspect your PHI (Protected Health Information). You may also have the right to request an amendment to your PHI, or request that the Larkspur Fire Protection District restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies that you may have upon request.

To assist the Larkspur Fire Protection District in processing your request, please indicate below the type of request you are making:

_____Access to review my PHI.

_____Access to obtain copies of my PHI (NOTE: If you wish request copies of your PHI via mail, ensure you complete page 2 of this form. Ensure the form is properly notarized prior to returning it to LFPD.).

_____Access to review and potentially request an amendment of my PHI.

_____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 PHI.

Signature: ___________________________________ Date: ___________________

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Please list the description of documents requested:

____

____

Please describe the purpose of your request:

____

____

By signing below I acknowledge and understand the following:

- Upon receipt and verification of this document, the Larkspur Fire Protection District is authorized by me to disclose the requested Protected Health Information to me or my authorized representative.
- Falsifying an official document is punishable in accordance with State and Federal Statutes.
- The released information contains Protected Health Information about me and I hereby consent to the release of such information.
- I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- The Larkspur Fire Protection District may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing this authorization.

____________________ ____________

Signature of Patient or Authorized Representative Date

____________________ ____________

Notary Public Signature & Stamp Date My Authorization Expires