

Washington Township/Avon Fire Department

Patient Request for Access Form

**Patient information can only be released to the patient or the patient's legal guardian.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ 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 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).**

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: _____

Printed Name: _____ Relationship to Patient: _____

INSTRUCTIONS:

1. Complete entire top section.
2. Return form with original signature.
3. Enclose a copy of your photo ID
4. Pre-Payment of \$10.00 - Required by check, money order or credit card

Drop off or mail to:
311 Production Dr.
Avon, IN 46123

Email to: cthacker@avonfd.org Fax to: 317-343-4243

How would you like to receive records? Email Fax Pickup Mail
Please provide information for receive request.

