Bangs Ambulance
Patient Accounting Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of certain uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from Bangs Ambulance. **NOTE: Bangs Ambulance is not required to provide you with an accounting of uses and disclosures associated with your treatment and transport, or for billing, payment or health care operations.**

Signature _____ *Request Date* _____

List of Uses and Disclosures

Date of Disclosure	Name/Address of Recipient	Purpose and Brief Description of Disclosure	PHI Disclosed

Additional Information:

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