

**Bangs Ambulance, Inc.**  
**Executor / Administrator Request for Access to Protected Health Information**

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Verification of Executor / Administrator identity (government issued photo ID) attach a copy

\_\_\_\_\_ Verification of Executor / Administrator Authority - attach a copy

**FEES:** Health records are subject to fees of \$.75 per page. Health records are released upon payment of fees.

**Right to Request Access to PHI and Our Duties:**

The Executor / Administrator has the right to inspect or obtain a copy of the deceased's protected health information ("PHI") that we maintain in a designated record set. If we maintain PHI in electronic format, then you also have a right to obtain a copy electronically. In addition, you may request that we transmit a copy of the deceased's PHI directly to another person and we will honor that request when required by law to do so. Requests to transmit PHI to another party must be in writing, signed by you, and clearly identify the designated person to whom the PHI should be sent, and where the PHI should be sent.

Generally, we will provide you access to the deceased's PHI within thirty (30) days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient. In limited circumstances, we may deny you access to the deceased's PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to the deceased's PHI, subject to the limits of applicable state law.

Below, please tell us what PHI you are requesting access to. Specify dates of service and other details that will allow Bangs Ambulance, Inc. to accurately and completely fulfill your request.

Patient Care Report Date of Service \_\_\_\_\_  Other \_\_\_\_\_

**Specify How You Would Like us to Provide Access:**

Please provide me with a copy of the deceased's PHI

Please mail a copy of the deceased's PHI to me at the above address

Please mail a copy of the deceased's PHI to the following:

Company \_\_\_\_\_ Attention \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please transmit via email a copy of the deceased's PHI to the following email \_\_\_\_\_

Please transmit via fax a copy of the deceased's PHI to the following fax number \_\_\_\_\_

I would like to inspect a copy of the deceased's PHI (We will arrange a convenient time during normal business hours)

**Signature of Requestor:** \_\_\_\_\_ **Request Date:** \_\_\_\_\_