Albuquerque Fire Rescue
Records Management Division
400 Roma Avenue, NW
Albuquerque, NM 87102-2123
Office (505)764-6333
Fax (505)764-6360

Patient Request for Access to Protected Health Information

Patient Name: _____ **Date of Birth:**_____

Social Security Number: _____ **Date of Injury:**_____

I,_____ authorize **Albuquerque Fire Rescue** to access, use or disclosure of the above named individual's protected health information (PHI) as described below.

Type of information used or disclosed:

☐ **Complete Medical Records** ☐ **Billing records** ☐ **Other:**_____

I understand that by signing this authorization:

- I authorize the access, use or disclosure of all my individually identifiable protected health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to access, use or disclose the information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Right to Request Access to Your PHI and Our Duties:

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have a right to obtain a copy of that information electronically. In addition, you may request that we transmit a copy of your 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 (or your representative), 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 (or your authorized representative) access to your PHI within thirty (30) days of your request. We will 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 (such as a power of attorney) or other information necessary to verify that the requestor has the right to access PHI. In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

_____ _____

Patient signature or legal representative **Date**

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient:_____