Request for Access to Protected Health Information

Patient Name:___________________________ Date:_____________________________

Address:____

City: _______________________ State: ______________ Zip Code:________________

Social Security No.: ______________Email:_______________Date of Birth__________

Right to Request Access to Your Protected Health Information and Our Duties

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information (PHI). If we maintain your PHI in electronic format, you also have a right to obtain a copy of that information electronically. In addition, you may request 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. Any PHI transmitted via email will be encrypted. Life Flight Network is not responsible for unauthorized access to PHI while in transmission to the requestor or designated party. Life Flight Network is not responsible for safeguarding PHI once delivered.

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 access 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 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.

Request for Access to Protected Health Information

Below, please specify dates of service, requested information (such as medical records, statements, etc.), and other details that will allow Life Flight Network to accurately and completely fulfill your request.

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Specify Method of Delivery

Please check all that apply.

____ Provide a copy directly to me.

☐ **Mail.** Please send a copy to me at the following address in the specified format:

Street: ____

City: ______________________State:______ Zip Code: ________

Format (Paper Copy or PDF files saved on disc):_______________

☐ **Email.** Please email a copy to me at the following email address in the specified format:

Email address: ___________________________________

____ Transmit a copy to a designated third party.

☐ **Mail.** Please send a copy to the following party in the specified format:

Designated Party:____________________________________

Street: ____

City: _________________________State:_______ Zip Code: _________

Format (Paper Copy or PDF files saved on disc):__________________

☐ **Email.** Please email a copy to the following party in the specified format:

Designated Party:____________________________________

Email address: ___________________________________

____ Inspect in person. I would like to inspect a copy of my PHI at Life Flight Network's place of business at 22285 Yellow Gate Lane, Suite 102, Aurora, OR 97002. The HIPAA Privacy Officer will arrange a convenient time for you to inspect a copy of your request during normal business hours.

____ ___________________

**Signature of Requestor Request Date

Requestor Information (if requestor is different from patient):

Name: ________________________________

***Relationship to Patient (parent, legal guardian, etc.):___________________________

Street Address: ____

City: ________________________State: ____________ Zip Code: _____________

**Must provide front and back copy of driver's license or other photo identification for verification of identity.

***If necessary, must provide copy of legal document on which authority to act on behalf of patient is based.