ROBERTSON COUNTY EMERGENCY MEDICAL SERVICE
PATIENT REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ PHONE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____ DATE OF BIRTH: _____

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. **If the PHI you request is maintained in our electronic health record system and you request it in electronic form, Texas law requires us to provide it no later than fifteen (15) business days after we receive your request** (Tex. Health & Safety Code §181.102). 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 (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.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OF YOUR PHI AND OUR DUTIES:

You (or your authorized representative) have the right to request that we send your PHI to an alternate location (*e.g.*, somewhere other than your home address), or in a specific manner (*e.g.*, by email rather than regular mail). We will only comply with reasonable requests when required by law to do so. We will notify you about our decision regarding your request by phone or email. Please provide us with appropriate contact information.

Note: This approval applies solely to the current request and does not constitute a standing authorization for future confidential communications. Any ongoing or recurring confidential communication accommodations must be formally requested by completing the "Patient Request for Confidential Communications of Protected Health Information" Form. Such requests will only be recognized and honored once the completed form has been reviewed, accepted, and is on file with Robertson County Emergency Medical Service.

REQUEST FOR ACCESS TO PHI:

Below, please describe the PHI that you are requesting access to with as much specificity as possible. Specify dates of service and other details that will allow Robertson County Emergency Medical Service to accurately and completely fulfill your request.

Date of Service or Range: _____

CFS or OCA number (if known): _____

Other info: _____

_____

_____

SPECIFY HOW YOU WOULD LIKE US TO PROVIDE ACCESS:

PLEASE CHECK ALL THAT APPLY AND FILL OUT THE REQUESTED INFORMATION, WHERE INDICATED.

NOTICE REGARDING UNENCRYPTED EMAIL

Robertson County Emergency Medical Service sends PHI by encrypted email. Unencrypted email can be intercepted or viewed by unauthorized persons while in transit. If you initial NON-ENCRYPTED below, you acknowledge that you have been informed of this risk and still choose to receive your PHI (or have it sent to your designated party) by unencrypted email. Robertson County Emergency Medical Service is not responsible for unauthorized access to your PHI that occurs during transmission after it is sent by unencrypted email at your request.

____ PLEASE PROVIDE ME WITH A COPY OF MY PHI

____ **MAIL.** PLEASE SEND A COPY OF MY PHI TO ME AT THE FOLLOWING ADDRESS:

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FORMAT (PAPER COPY, DIGITAL COPY ON A DISC, ETC.): _____

____ **EMAIL.** PLEASE EMAIL A COPY OF MY PHI TO THE FOLLOWING EMAIL ADDRESS:

EMAIL ADDRESS: _____

_____ (INITIAL) ENCRYPTED

_____ (INITIAL) NON-ENCRYPTED — I have read the unencrypted email notice above

____ **IN-PERSON PICKUP.** PICK UP THE RECORD(S) IN PERSON FROM THE ROBERTSON COUNTY EMERGENCY MEDICAL SERVICE OFFICE.

_____ PLEASE TRANSMIT A COPY OF MY PHI TO THE FOLLOWING PARTY AT THE FOLLOWING MAILING ADDRESS OR EMAIL ADDRESS IN THE SPECIFIED FORMAT:

DESIGNATED PARTY: _____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____

_____ (INITIAL) ENCRYPTED

_____ (INITIAL) NON-ENCRYPTED — I have read the unencrypted email notice above

FORMAT (EMAIL OR MAIL): _____

_____ I WOULD LIKE TO INSPECT A COPY OF MY PHI AT ROBERTSON COUNTY EMERGENCY MEDICAL SERVICE'S PLACE OF BUSINESS. (Robertson County Emergency Medical Service will arrange a convenient time and place for you to inspect a copy of your PHI 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: _____

OFFICE USE ONLY

Date Received: _____ Received Via (in person / mail / email / fax): _____

Delivery type / response deadline (check one):

_____ Electronic copy from EHR/ePCR — due within **15 business days** of receipt (Tex. Health & Safety Code §181.102)

_____ Paper or other non-electronic copy, or inspection — due within **30 calendar days** of receipt

Response Due Date: _____ Date Completed: _____

ID Verified Via: _____

Representative Authority Verified Via (if applicable): _____

Approved by: _____
Coleman French, HIPAA Compliance Officer