MOBILE MEDICAL RESPONSE, INC.
REQUEST FOR ACCESS TO PHI

The undersigned individual hereby requests access to his/her protected health information (PHI) or is the legally authorized representative for the patient, contained in a designated record set, as follows:

Patient Name:_____ **Date of Service:**_____
Date of Birth: _____**SSN: XXX-XX-**_____ **Location of call:**_____
Phone Number:_____

The request is to:

☐ See the record or records ☐ Receive a copy of record or records
There is a small charge to cover the costs of copying run reports.

Reports will be:

☐ Picked up (phone#:_____) ☑ Faxed: (248) 585 5822

☑ Mailed: 3905 Rochester Road, Royal Oak, MI 48073

IDENTIFICATION OF PATIENT ASCERTAINED BY: ***Requires two separate documents for verification)***

ID Card (Pictured):_____ State issued:_____ Expiration Date:_____

Drivers License #_____ Expiration Date:_____ State issued:_____

Social Security Card:_____ Other Identification:_____
Describe

Signature: _____ Date:_____

Please have your signature witnessed and notarized if you are mailing or faxing this form.

On this ____ day of _____, 20___, personally appeared _____
Patient or legally authorized representative for_____
_____, Notary, _____County

Action taken in response to the forgoing request: SEAL

☐ Accepted in Full

If partially accepted, state the part that is accepted: _____

If partially or wholly denied, state the reasons: _____

Date signed: _____ MMR Rep: _____

Title: _____

Mobile Medical Response, Inc.
834 S. Washington
Saginaw, Michigan 48601
989-758-2900