Ambulance Billing Office
1705 W. 2nd Avenue
Eugene, OR 97402
(541) 682-7108
(541) 682-7168 FAX

Ambulance Account Services
Patient Request for Medical Records Access
To Use and Disclose Protected Health Information and Records

Patient Rights: As a patient, you have the right to access, copy, or inspect your protected health information (PHI) in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our *Notice of Privacy Practices* and in other policies which you may have upon request.

Please fill in all information and return the completed form to the Ambulance Billing Office.

Patient Name: ______________________ Date of Request: ______________________

Phone Number: ______________________ Patient Date of Birth: ______________________

Address: ____

City: ______________________ State: ____________ Zip: ____________

Date of Ambulance Transport Service: ______________________ Run/Invoice #: ______________________

Please indicate how you would like the requested information to be sent:

☐ Mail *(provide mailing address if different from above)*

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☐ Email ______________________ ☐ Fax ______________________

If acting with Power of Attorney or as a Personal Representative, please provide full name and relationship to Patient *(If other than a spouse or parent, provide copy of authority, i.e. POA)*:

Full Name: ______________________ Relationship: ______________________

Patient or Legal Representative Signature: ______________________ Date: ______________________

This request must be accompanied by a copy of your picture ID.
If you are unable to provide picture identification, this request must be notarized below.

State of ______________________ County of ______________________

Signed or attested before me on ______________________, 20____ by ______________________

Notary Public

***For Internal Office Use Only* – Date Received:** ______________ **Received by:** ______________

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