# Tacoma Fire Department
## Patient Request for Access Form

(This form is for personal use only. This is not a replacement form for legal and law enforcement requests)

Patient Name: ________________________________________________

Phone Number: ____________________ Email Address: ________________________

Address: ____________________________________________________

City: ____________________________ State: _________ Zip Code: ___________

Last Date of Service: ___________________________

Location of Service: ____________________________

How you want your information provided:

| Registered Email | Regular Email | Mail | In-Person |
|---|---|---|---|
| (Most Secure) | (Not as secure, you release any liability from the Tacoma Fire Department.) | (Least secure, we are not responsible if documents are lost or stolen.) | (We try to provide same day, but we are allowed up to 30 days of the day we receive this form, as stated in our Notice of Privacy Practices.) |

*Patient Rights:* As a patient, you have the right to access, copy, or inspect your protected health information, or 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.

To better allow us to process your request, please indicate the type of request you are making on this form: [check all that apply]

Access to review my health information.

Access to obtain copies of my health information.

Access to review and potentially request amendment of my health information.

Access to review and potentially request an accounting of how my PHI has been used been used and disclosed to others.

Access to review and potentially request restrictions on the use and disclosure of my health information.

Access to health information for someone other than myself.

*Signature* ____________________________________ *Request Date* _______________

**PICTURE IDENTIFICATION MUST BE PROVIDED IN ORDER TO RECEIVE A COPY OF YOUR REPORT.**

***FOR OFFICE USE ONLY***

Incident # _________________________ Incident date _______________________

- ❑ Privacy officer/designee - authorization to release copy of EPCR to the patient
- ❑ EPCR provided to patient

_____ Privacy Officer Approval (as necessary)