WESTSIDE AMBULANCE ASSOCIATION
PO BOX 4527
Orland, Ca 95963
Phone 530 865-3998
Fax 530 865-5981
WESTSIDEAMBULANCE@SBCGLOBAL.NET

REQUEST FOR ACCESS TO HEALTH INFORMATION IN A DESIGNATED RECORD SET HELD BY WESTSIDE AMBULANCE ASSOCIATION

1. Name of Requesting Individual:________________________Date of Service requested_____________
2. Name of Patient (if not requesting individual):__________________ Date of Birth________________________
3. Indicate below the method of access to your health information that you are requesting:
   ______Inspection of health information
   ______A Copy of the health information
   ______Both inspection and a copy of health information
   ______A summary of the health information prepared by Westside Ambulance Association instead of access to all of the health information
4. Indicate below the format of access that you are requesting:
   ______Paper copy of the health information
   ______Other. Please describe:____

Information about your access rights:

Except under limited circumstances, we will provide you with the access you request. We will respond to your request for access within 30 days (or 60 days if the extra time is needed) from the time we receive this completed form. In certain situations we may deny your request, but if we do, we will notify you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

Where to Submit this Form:

You must submit this form to Office Personnel at Westside Ambulance Association

By mail: PO BOX 4527,Orland, Ca 95963
By Fax: (530)865-5981
By email: westsideambulance@sbcglobal.net

By submitting this form, I hereby request Westside Ambulance Association to provide me with access to my health information that Westside Ambulance Association maintains.

Name:__________________________Address to mail records:__________________________________

Signature of patient or legal representative: ______________________ Date:_____________________
Relationship of representative to patient _________________________

Name of Workforce Member who received this form:____
Date form Received____