

**CHESTER AMBULANCE SERVICE**

PO Box 370  
556 Elm Street  
Chester, VT 05143

**Request To Access Protected Health Information Records**

The individual for whom access is being requested:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Records you wish to access:

\_\_\_ Patient Run Reports for the following date/s of service: \_\_\_\_\_

\_\_\_ Protected Health Information Disclosure Log

How would you like to access your information?

\_\_\_ Paper Copy via US Mail      \_\_\_ In Person (You will be contacted to arrange a date and time)

I understand that I may be charged a nominal fee for any copies produced while granting this request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Individual or Personal Representative)

If signed by a Personal Representative, please complete the following:

Representatives Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Representative's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Send this form to our Privacy Officer at the address above.

