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Myrtle Beach, SC 29579
24 Hour Dispatch Line:
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Patient Access Request Form

Date: _____

Patient Name: _____ Soc. Sec. No. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Service: _____

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.

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 simply 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 and disclosed to others.

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

Signature _____ Request Date _____

Failure to complete this form, in its entirety, will result in delays and/or the inability to fulfill your request.