crowdRx
A Global Medical Response Solution

Patient Request for Access to Protected Health Information

Patient Name: _____ Phone: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ E-Mail: _____

____ Verification of patient's identity (government issued photo ID) attach a copy
____ Verification of patient's personal representative identity (government issued photo ID & authority document) attach a copy

Right to Request Access to Your PHI and Our Duties:

You (or your authorized representative) have the right to inspect or obtain a copy of your protected health information ("PHI") that we maintain in a designated record set. If we maintain your PHI in electronic format, then you also have a right to obtain a copy electronically. In addition, you may request that we transmit a copy of your PHI to another person and we will honor that request when required by law to do so. Requests to transmit PHI to another party must be in writing, signed by you (or your representative), and clearly identify the designated person to whom the PHI should be sent, and where it should be sent.

Generally, we will provide you (or your authorized representative) access to your PHI within thirty (30) days of your request. We may verify the identity of any person who requests access to PHI, as well as the authority of the person to have access to the PHI by asking the requestor to provide the patient's social security number, date of birth, legal authority to act on behalf of the patient (such as a power of attorney). In limited circumstances, we may deny you access to your PHI, and you may appeal certain types of denials. We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

Below, please tell us what PHI you are requesting access to. Specify dates of service, venue, and other details that will allow GMR Event Services LLC dba CrowdRx to accurately and completely fulfill your request.

Date of Service: _____ Venue or Event Name: _____

Specify How You Would Like us to Provide Access:

[ ] Please mail a copy of my PHI to me at the above address.

[ ] Please mail a copy of my PHI to the following address:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

[ ] Please transmit via email a copy of my PHI to the following email: _____

[ ] I would like to inspect a copy of my PHI (We will arrange a convenient time during normal business hours)

Signature of Requestor: _____ **Request Date:** _____

This form must be mailed to:
CrowdRx
Attn: Patient Records
429 Lenox Avenue, Miami Beach, FL 33139