SOUTHERN CHESTER COUNTY
EMERGENCY MEDICAL SERVICES
PO Box 8102 West Grove, PA 19390
610.910.3180
www.sccems.org

Authorization for Release for Medical Records

Patient Name: _____ Date of Service: _____

Address of Service: _____

Patient DOB___/____/_____ Type of Response_____

Patient Address:_____

City: _____ State: _____ Zip Code: _____

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 and in other policies which you may have upon request.

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.

[Select one]

- ☐ Please mail the requested information to:_____
- ☐ Please e-mail the requested information to me at _____
- ☐ Please fax the requested information to me at _____
- ☐ Please e-mail the requested information to my physician _____ at _____

Signature _____ *Request Date* _____