



**REQUEST FOR ACCESS TO HEALTH INFORMATION  
IN A DESIGNATED RECORD SET HELD BY  
The San Marcos Fire Department. FORM HIPAA**

1. Name of requesting individual:

\_\_\_\_\_

2. Relation of individual to the patient:

Patient     Spouse     Parent/Guardian     Legal representative

If not the patient, patient's name: \_\_\_\_\_

3. Date of incident: \_\_\_\_\_

4. Incident location: \_\_\_\_\_

5. Indicate below the information you are requesting:

EMS report     Ambulance Bill     Other: \_\_\_\_\_

**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 10 days from the time we receive this completed form. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

**Charges for Access**

We will charge you \$15.00 for your request. If you do not agree to the charge, we will not prepare the summary.

**Substantiating Information**

A copy of your Driver's License or DMV issued Identification Card **MUST** be submitted with this request.

If you are not the patient requesting the information, you must also submit documentation of legal representation and/or responsibility.

**Where to Submit this Form**

You must submit this form to the City Clerk, 1 Civic Center Drive, San Marcos, California 92069-2918

By submitting this form, I hereby request the Organization to provide me with access to my health information that the Organization maintains.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Internal use only*

Name of Workforce Member who received this form: \_\_\_\_\_

Date form received: \_\_\_\_\_