

F-1001 HIPAA – Health Record Request

PATIENT INFORMATION

		Date
		Date of Birth
Name (Last, First, Middle initial)		
		Email address
Street address, City, ST, ZIP Code		
		Fax number
Primary phone number Other phone number		

Items Requested (Select all that apply)

- | | | |
|--|--|--|
| ☐ Electronic Medical Record | ☐ Financial Information | ☐ Nutrition Assessments |
| ☐ Individual Care Plans | ☐ FMS Assessments | ☐ Accounting of Disclosures |

Please describe the type of information requested **in detail**.

Method of Release (Select one)

- | | | |
|------------------------------------|--|--|
| ☐ In person | ☐ Mailed (address listed above) | ☐ Fax (as listed above) |
|------------------------------------|--|--|

Do you authorize anyone to receive the Health Record items on your behalf?

- | | |
|-----------------------------|--|
| ☐ No | ☐ Yes, I authorize _____ to receive the requested items |
|-----------------------------|--|

Relation to requestee _____

Please indicate an acceptable method of contact (Select all that apply)

By selecting this method of contact I am giving **Plan2Peak, Inc.** my consent to contact me by the indicated means when the Health Record items requested are available.

- | | |
|--|--|
| ☐ Mailing Address (as listed above) | ☐ Primary Phone (as listed above) |
| ☐ Email (as listed above) | ☐ Other Phone (as listed above) |

Do you authorize **Plan2Peak, Inc.** to leave a phone message?

- | | |
|------------------------------|-----------------------------|
| ☐ Yes | ☐ No |
|------------------------------|-----------------------------|

Please list **Plan2Peak, Inc.** staff member that was contacted regarding this matter:

		Date
Name of Plan2Peak, Inc. staff member		
		Date
Patient (or legal health representative) Signature		
Depending on the size of the request, Plan2Peak, Inc. may require up to 30 days to complete the request and will contact you when a printed file is available.		
(Attach additional documentation, if applicable.)		

For Administrative Use Only:	
	Date received
Action taken	
	Date
Action taken	
	Date
HIPAA Compliance Officer Signature	Date