



Request to Access Health Information Retained in Designated Record Sets

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____ - ____ - ____ Medical Record #: _____ Phone: _____

Address: _____ City: _____ ST: ____ Zip: _____

Records to which access is requested (please describe below): Actual copy Summary or Explanation

Please send this accounting by:

- Paper Copy (call at number above to pick up or mail to address above)
- Email _____ or other electronic method _____

I understand that this request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that access may be denied and I will be notified of the basis for the denial.

SIGNATURE OF INDIVIDUAL DATE OR _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

RELATIONSHIP TO INDIVIDUAL

- You may submit this form:**
- In person: to the nearest Concentra medical center
 - By mail: Concentra Privacy Office
P O Box 1438
Louisville, KY 40202-1438
 - By fax: 502.508.3700
 - By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY

Complete the sections below and email this request to PrivacyOffice@Concentra.com or fax to 502.508.3700

Date Request Received: _____ mail in person email fax Date sent to Privacy Office: _____

The request for access is: **Approved and provided per request** **Denied for reason indicated below:**
(only the Privacy Office will communicate denials to the patient)

- Information requested is not a part of patient's designated record set.
- Information requested is not available to the patient for access as required by federal or state law.
- A physician has determined that access to information requested may endanger the life or physical safety of the individual or another person.
- Other: _____

Physician who reviewed if applicable Title Phone Date completed

Staff member who processed request Title Phone Date completed

Center Name Location Number

