Concentra®

Patient – Access Request

Form is used for the patient (or his/her personal representative) to request access to the patient's protected health information (PHI). Concentra.com has contact information of active facilities for completed form submission. Contact the Privacy Office if visit was at a no longer active facility.

Patient Information

Name: _____

Name at Date of Service (If Different Than Above): _____

Date of Birth: _____

Address: _____ **City:** _____ **St:** ___ **Zip:** _____

Fax Number: _____ **Confirmation Phone Number:** _____ **Email:** _____

Facility Visited

Facility Name: _____

Please Mark (If Applicable): ☐ Closed Site ☐ Onsite ☐ Telemedicine

Requested Records

Date(s) of Service: _____

☐ Complete Medical Record ☐ Lab Results ☐ Physician Orders ☐ Prescriptions ☐ Itemized Bill ☐ X-ray

☐ Other: _____

Preferred Delivery Method

☐ Mail ☐ Call at Number to Pick Up ☐ Fax ☐ Secure Email [Mark an X here___if unencrypted email preferred despite risk]

☐ Other Electronic Method (USB, CD, Other): Please Specify: _____

Personal Representative Information (If Applicable)

Name: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **St:** ___ **Zip:** _____

Fax Number: _____ **Confirmation Phone Number:** _____ **Email:** _____

Requestor Signature Check Box ☐ Patient ☐ Personal Representative

Patient Name: _____ **Signature:** _____ **Date:** _____

Representative Name: _____ **Signature:** _____ **Date:** _____

For Health Insurance Portability and Accountability Act (HIPAA) questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571.

Concentra® recognizes a patient's rights under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

CONPPARAA