anewhealth

Request to Access Patient Records

Section 1: Patient's Personal Information

Name: _____ DOB: _____

Address: _____ Telephone: _____

_____

Section 2: Proof of Identity

Driver's License: _____ ☐ Passport Number: _____

Guardianship Documentation: _____

Covered Entity Request for Documentation: _____

I understand that upon granting access to requested records, the Company will provide these records within thirty (30) days of receipt of request. In addition, I understand there may be a cost-based fee charged to process this request. The Company will contact me prior to continuing action on this request for my approval of the fee amount.

The Company retains PHI records and associated documents for six (6) years from the date of last action.

Section 3: Request for PHI Information

- ☐ Patient File
- ☐ Payment Information
- ☐ Insurance Data
- ☐ Prescription/Medical File
- ☐ Prescription Hard Copy
- ☐ Other

Format Requested:

- ☐ Hard Copy
- ☐ Electronic Format
- ☐ Other

I understand there may be a fee assessed for providing my request which would include: SUPPLIES, LABOR AND POSTAGE.

Patient Signature: _____ **Date:** _____

Legal Representative/Guardian Signature: _____ **Date:** _____

Relationship to Individual: _____

Submit this completed request to the facility or mail to:

AnewHealth
ATTN: Privacy Officer
8333 Rockside Road
Valley View, OH 44125-6126

***Office Use Only* – Please Do Not Write Below This Space**

Date Request Received: _____ Date Approved: _____ Fee for Service: Yes/No

Date Provided to Patient: _____ Format Provided: _____ Total Cost: _____