Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1001 HIPAA – Health Record Request

PATIENT INFORMATION

Date

Name (Last, First, Middle initial) | Date of Birth

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

Items Requested (Select all that apply)

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

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

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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 Restore Medical Fitness my consent to contact me by the indicated means when the Health Record items requested are available.

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

Do you authorize Restore Medical Fitness to leave a phone message?

☐ Yes ☐ No

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

Name of Restore Medical Fitness staff member | Date

Patient (or legal health representative) Signature | Date

Depending on the size of the request, Restore Medical Fitness 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