# Request to Access Protected Health Information (PHI)

Patient Name:_____
Last First MI Maiden or Other Name

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

Address:_____City:_____ST: _____Zip:_____

Facility Visited _____ Approximate date:_____
Type of access requested: ❑ Actual Copy ❑ Summary or explanation ❑ View on Site
Reason for Visit: ❑ Primary Care ❑ Work Related ❑ Urgent Care ❑ Other

**Type of Record (please describe below):** _____
_____

**Please send records** ❑ To me OR ❑ To:
_____ **by:**
**(Name and Address, if mailing)**

By: ❑ Paper Copy ❑ call at number above to pick up or ❑ mail by USPS to address above
* ❑ Email _____ or ❑ other electronic method _____
*For security of your records, all emails are sent encrypted.

**Unencrypted email disclaimer:**

❑ I understand that records sent through unencrypted email pose a security risk but it is my requested method of receipt._____(Please initial)

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.

_____ _____ OR _____ _____
SIGNATURE OF INDIVIDUAL DATE 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
  5080 Spectrum DR, Ste 1200 West, Addison, TX 75001
  ATTN: Privacy Office
- By fax: 214-775-4408
- By email: PrivacyOffice@concentra.com

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**FOR INTERNAL USE ONLY**

Complete the sections below and email this request to PrivacyOffice@Concentra.com or fax to 214.775.4408 with all records referenced in the request.

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

_____ _____
Facility Name Location Number (if applicable)