

Take Care Health Systems, LLC
4165 30th Avenue Southwest, Fargo, ND 58104
Phone: 1-866-Take Care (1-866-825-3227) Fax: (701) 277-0352

REQUEST TO ACCESS, INSPECT, OR OBTAIN PROTECTED HEALTH INFORMATION**Request**

I request to review health information held about me in the Take Care Health Medical Records in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that Take Care Health has 30 days to respond to this request, and that if someone else holds the information or it is off-site, the response time is 60 days.

Optional: The purpose of requesting this information is:

Information:

Please list the address to which the Medical Records should be mailed:

Patient Name: _____ Date of Birth: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____ Fax: _____
Email Address: _____

Standard requests for records contain fifteen (15) month time period. If your request for records is in excess of fifteen (15) months, please indicate the time frame below. Records are retained in accordance with relevant laws from state to state.

From _____ to _____

Agreement

I agree that Take Care Health may provide a summary of health information instead of allowing me to review the information (check one): Yes No

I understand that this request does not apply to certain health information, including: (1) information that is not held in the designated record set; (2) information compiled in reasonable anticipation of or for litigation; and (3) other information not subject to the right to access information under HIPAA.

I agree to pay any fees for copying or summarizing my health information. Fees will be reasonable and cost-based, and include only the cost of copying, postage, and preparation of a summary (if I agree to a summary).

Signature

Signature

Date

If signed by the patient's personal representative, explain authority to act on behalf of the patient

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information.