Medical Record Request Information

General Medical Record Contact Information

Connections Health Solutions
Attn: Medical Records Department
2390 East Camelback Road, Suite 400
Phoenix, AZ 85016
(602) 416 – 7657

Medical Records Information by State

To send requests use information below:

Arizona
Email: medicalrecords@Connectionshs.com Fax: 602-362-3231

Montana
Email: medicalrecordsMT@Connectionshs.com Fax: 602-362-3231

Virginia
Email: medicalrecordsVA@Connectionshs.com Fax: 703-270-0005

Washington
Email: medicalrecordsWA@Connectionshs.com Fax: 425-217-1179

Pennsylvania
Email: medicalrecordsPA@connectionshs.com Fax: 717-408-9284

CONNECTIONS
Health Solutions

Recipient/Individual Request for Access of Protected Health Information (PHI)

You have the right to request access to your PHI maintained by Connections Health Solutions (Connections) in our designated record set. Certain information is excluded from access, including:

- **Information meeting the definition of Psychotherapy Notes.**
- **Information compiled by Connections in reasonable anticipation of, or for use in, a civil or criminal or administrative proceeding,**
- **Information obtained from someone else, if providing you the access you requested would be reasonably likely to violate that person's confidentiality by revealing the source.**
- **Information that a licensed health professional has, in the exercise of professional judgement, determined that access you have requested is reasonably likely to endanger the life or physical safety of you or another person, cause substantial harm to another person referenced in your record or cause substantial harm to you or another person.**

I, _____ _____ _____

Patient Name **DOB** **Date**

I am requesting a copy of my Protected Health Information (PHI) pursuant to the HIPAA Right of Access regulations. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use.
I am requesting records from Connections Health Solutions.

Please produce records from the following dates:____ /____/____ to ____ /____ /____

SPECIFIC PHI TO RELEASE - (Check box of items to be released)

☐**Medications** ☐**Psychiatric Evaluation** ☐**Progress Notes** ☐**Treatment Plan** ☐**Diagnostic Information**
☐**Lab results** ☐**Appointments** ☐**Financial** ☐**Assessments** ☐**Discharge Summary**
☐**Insurance/Demographic Information** ☐**Other Information:** _____

☐**Entire Chart** (I understand the medical records I am requesting may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. Documents included in your entire chart may include assessments, diagnostic information, treatment plans, medication information, Psychiatric evaluation, clinical progress notes (including progress in treatment), labs, financial and insurance information, discharge information, and any other information used to make decisions about your treatment)

IMPORTANT INFORMATION: I understand that if I ask Connections to disclose PHI to another individual or entity, that information may no longer be protected by State and Federal privacy laws, including HIPAA. I understand that Connections will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand Connections will call to discuss alternative delivery options. In certain limited circumstances, Connections may deny a request. If a request is denied, I understand I will be given a written explanation, and a description of steps I may take in response to the denial.

I am requesting that this PHI be released in the selected form or format to:

☐**Myself**
☐**Designated person/entity**

Name: _____

Address: _____

_____

Phone/Fax#: _____

Format Requested:
View On-Site _____
Paper: _____ (Mail or Pick-Up)
Fax: _____
Email: _____
Other: _____

The email will be sent secured to protect your PHI, so additional steps need to be taken to access the information.

Date/Time: _____ Patient Signature:_____

Verbal request: _____ CHS Staff Person: _____

If patient is unable to sign authorization form because of physical condition or age, complete the following:

Patient unable to sign because :_____

Description of Personal Reps (PR)/Guardian authority to act for the patient: _____.

Date/Time: _____ PR Signature/Guardian (If indicated): _____

Revised: 06/07/2021, 08/04/2022, 9/20/2022, 2/20/2024, 2/21/2025, 3/11/2025