



Request for Health Information

The undersigned patient, or patient's personal representative hereby requests:

- To review the below-named patient's medical record; or
- To obtain a copies of the below-named patient's medical record.

Patient Name _____

Social Security Number _____ Date of Birth _____

Address _____

City/State/Zip _____

Telephone _____ Fax Number _____
(include area code) (include area code)

For services from _____ to _____
(date) (date)

Purpose _____

I understand that Matria Healthcare, Inc. will attempt to provide the requested records that are maintained on-site no later than thirty (30) days from the date of Matria's receipt of my request. If my records are maintained off-site, Matria will provide the records no later than sixty (60) days from the date of receipt of my request. I understand that Matria will notify me in writing that an extension of up to thirty (30) days is needed if they are unable to provide access within the timeframe(s) listed above.

I agree to pay a fee for the copying and postage expenses associated with my request.

I understand that Matria Healthcare, Inc. may not be required by law to make available all or part of the records requested. In that circumstance, Matria Healthcare, Inc. will notify me of that fact in writing within thirty (30) days of receipt of my request, indicate the reason the record has not been made available, and specify my rights to a review of the denial.

Name of Patient or
Personal Representative *(PLEASE PRINT)* _____

Signature of Patient or
Personal Representative: _____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Signature of Witness: _____ Date: _____

Please submit this form directly to:

Privacy Officer
Matria Healthcare, Inc.
1850 Parkway Place Suite 1200
Marietta, GA 30067
Fax Number: 770-767-4588

If you have any questions, please contact Privacy Officer directly at 770-767-8191

For Matria Use Only: Date that this request was received by Matria _____

Request Disposition _____ Approved _____ Denied