

VERITAS ONE, INC.
MEDICAL RECORDS REQUEST (PATIENT ACCESS) — FAX COVER

RETURN FAX (SECURE): [Your Secure Fax Number]

ALTERNATE SECURE DELIVERY: ~~RECEIVER~~@veritasone.com or SFTP

CONTACT (QUESTIONS): [Your Phone] | [Your Address]

TO (HIM/ROI): test

PROVIDER FAX: +1-938-336-4787

PHONE: [PROVIDER PHONE]

FROM: Veritas One, Inc. (designated agent for the patient)

DATE: November 13, 2025

PAGES (INCLUDING COVER): 3

REQUEST ID: 10

PATIENT INFORMATION

PATIENT: Test Three

DOB: 1979-01-01

PHONE: 555-555-5555

EMAIL: test.three@test.com

OPTIONAL IDENTIFIERS: MRN [] | LAST 4 SSN []

RECORDS REQUESTED (DESIGNATED RECORD SET)

- ALL RECORDS, ALL DATES (clinical + billing; radiology reports & images)
- DATE RANGE: [FROM] to [TO]
- SPECIFIC DOCUMENTS: _____

SENSITIVE CATEGORIES (RELEASE IF INITIALED ON ATTACHED AUTHORIZATION)

HIV/STD _____ GENETIC _____ REPRODUCTIVE/SEXUAL HEALTH _____

MENTAL/BEHAVIORAL HEALTH (non-psychotherapy) _____ SUD/42 CFR PART 2 _____

NOTE: PSYCHOTHERAPY NOTES REQUIRE A SEPARATE SPECIFIC AUTHORIZATION.

DELIVERY (FORM/FORMAT REQUESTED)

- Fax to return number above
- Secure electronic delivery (upload/SFTP/Direct/portal)
- Encrypted email

AUTHORITY & TIMING (HIPAA RIGHT OF ACCESS)

Patient-directed access request under 45 C.F.R. §164.524. Please respond as promptly as possible and no later than 30 days from receipt (one 30-day extension with written notice). Fees must be reasonable and cost-based.

ATTACHMENTS

- (1) Patient-signed HIPAA authorization (expires 180 days unless otherwise stated)
- (2) [Optional] Photo ID

CONFIDENTIALITY NOTICE:

This fax may contain protected health information (PHI). If you received it in error, notify the sender and destroy all copies.

42 C.F.R. PART 2 NOTICE (IF APPLICABLE):

This information has been disclosed to you from records protected by 42 C.F.R. Part 2. Redisclosure is prohibited unless permitted by the patient's consent or by Part 2.