VERITAS ONE, INC.

MEDICAL RECORDS REQUEST (PATIENT ACCESS) — FAX COVER

RETURN FAX (SECURE): [Your Secure Fax Number]
ALTERNATE SECURE DELIVERY: secure@veritasone.com or SFTP
CONTACT (QUESTIONS): [Your Phone] | [Your Address]

TO (HIM/ROI): **test clinic**
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: 9

PATIENT INFORMATION

PATIENT: **John Smith** **DOB:** 2001-01-01
PHONE: 555-555-5555 EMAIL: john.smith@email.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.