Request for Medical Records

HealthSmart Benefit Solutions, Inc.
PO Box 3244
Charleston, WV 25332-3244

Date	
Patient Name	**Patient Date of Birth**
HealthSmart ID# or Subscriber SSN	

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. See 45 C.F.R. § 164.524(b)
I request copies of the following health records:

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I understand you may charge a reasonable fee for copying the records and postage, but will not charge for time spent locating the records. Please mail the requested records to me at the following address:

Mailing Address:

I look forward to receiving the above records within 30 days as specified under HIPAA. If my request cannot be honored within 30 days, please inform me of this by letter as well as the date I might expect to receive my records.

Patient Signature

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