Records Access Request Form

ENPOINTE FLEXIBLE SPENDING PLAN – MEDICAL REIMBURSEMENT ACCOUNT
Health Plan/OHCA Name

I hereby request a copy of my medical record as detailed below:

- ☐ Full medical record held by this office
- ☐ Medical record for the period _____ through _____
- ☐ A specific portion/section of the record as follows:

_____

_____

_____

I understand that, unless otherwise provided by law, the charge for this record will be $0.25 per page for each page copied. I agree to pay this charge in full at the time I receive the copy of the record.

Covered Person:		
Requested By:	Relationship:	
Signature:	Request Date:	
Address:		
City:	State:	ZIP: