

Polk County Payer Request for Protected Health Information

Date: _____

Provide the name, title, organization and phone number of person making request:

We are requesting records for:

Patient's Full Name: _____

SSN or Other Patient Identifier: _____

Our organization has or has had a relationship with this patient:

- Yes
- No

We are seeking this information:

- To accommodate payment for services provided by Polk County
- Other
 - For operational needs
 - For fraud or abuse detection or compliance issues
 - For marketing

Since the request is for reasons other than payment, here is a list of information about the patient that is the minimum necessary needed by our organization to achieve the purpose stated above.

Our organization is a "covered entity" as defined by the Health Insurance Portability and Accountability Act:

- Yes
- No

Signature of requestor: _____ Date: _____