CyncHealth Health Information Request Form

CyncHealth offers patients the opportunity to request an access audit of their medical records contained within the CyncHealth. This request, which can be made annually free of charge, will inform you which healthcare providers, if any, have accessed your medical records through CyncHealth. Upon receipt of your completed and notarized request, we will begin to process it. You will be contacted with the results within 4 weeks.

- **Instructions:** To submit your request, please print and complete this form. A contact phone number is required in case CyncHealth needs to contact you to verify any information you provided.

☐ **Check here if you want to receive the results of this request at the email address you provided below**

Patient's Last Name:	Patient's First Name:	Middle Initial:	Previous Name or Nicknames:
Patient's Date of Birth:	Email:		Primary Phone Number:
Postal Address:	City:	State:	Zip:

For your protection, CyncHealth requires that your identity be verified, and your signature witnessed by a Notary Public to process this request. The original signatures must be in black or blue ink.

Signature of Patient:

____Date:_____________

If the patient is under 18 years, the Signature of the Parent or Guardian is required below:

Parent or Guardian: __________________________________ Relationship to Patient:___________________________
Date:____________

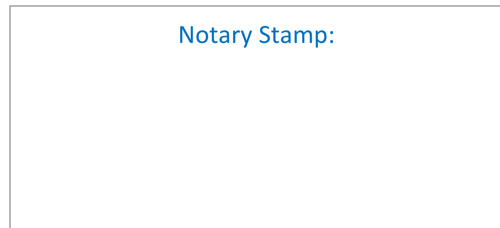
-------- -------- -------- -------- -------- -------- **Section below to be completed by a Notary Public** -------- -------- -------- ----------------

State of _________________________________ County of __________________________________

The foregoing instrument was acknowledged before me this _______________ by ________________________________.
(date) (name of person acknowledged)

Notary Print Name: ____

Notary Signature: ____



Email the completed notarized form to support@cynchealth.org

Or mail the completed notarized form to:

CyncHealth Privacy Office
P.O. Box 27842
Omaha, NE 68127

CyncHealth Staff Use Only *Received by:* ______________________________________ *Date:* ______________
STAFF NAME AND DEPARTMENT