level2®

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form will allow you as a Level2 member to request access to Protected Health Information (PHI) that Level2 Medical Services, P.A.[1] maintains and that was created or received during your enrollment in Level2. An * indicates a required field.

1: VERIFICATION (PLEASE PROVIDE CURRENT INFORMATION)

Patient/Member Full Name*:		
Patient/Member Mailing Street Address*:		**Apt. #:**
City*:	**State*:**	**Zip*:**
Patient/Member Date of Birth*:	**Patient/Member Phone Number*:**	
Member ID Number:		

2: INFORMATION REQUESTED*

☐ **All of my PHI, including my health information from (insert date)**			**to (insert date)**
☐ **All of my PHI maintained, created and/or received at Level2 during my enrollment with Level2**			
☐ **CGM Data**	☐ **Medication List**	☐ **Lab Test Reports**	☐ **Care Team Consult Notes**
☐ **Other:**			
Note: You may not be entitled to receive all of your PHI and may not receive information such as psychotherapy notes (if any) or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.			

3: METHOD OF DELIVERY*

☐ **Mail (Provide Name and Full Mailing Address):**
☐ **Level2 Patient Portal**
☐ **Email (Provide Email Address):**
Note: Email may not always be a secure method of sharing your information. By choosing this option and signing this form, you agree to any risks associated with this delivery method.

[1] The Level2 telehealth physician practices include: Level2 Medical Services, P.A. (DE); Level 2 Medical Services, P.C. (AK); Level 2 Medical Services P.C. (CA); Level2 Medical Services, P.A. (NJ); Level 2 Medical Services, P.C. (UT); and any other physician practice that now or in the future becomes an affiliated Level2 telehealth physician practice.

D 11000 Optum Cir, MN103-0300, Eden Prairie, MN 55344 P 1-844-302-2821, TTY: 711 W mylevel2.com

Rev. 3/16/2023

4: SIGNATURE*

A. Member:
I have read and understand the above information.

Signature of Member: **Date:**

Or,

B. Authorized person designated by Personal Representative who is legally appointed:
I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the member and will attach the appropriate documentation verifying my legal authority to this request.

Personal Representative's Signature: **Date:**

Personal Representative's Printed Name:

5: RETURN THE COMPLETED FORM

Mail:

Level2 Medical Services, P.A.
ATTN: Medical Records
11000 Optum Circle, MN103-0300
Eden Prairie, MN 55344

OR

Email:

Level2MedicalRecords@mylevel2.com

PLEASE KEEP A COPY OF THIS DOCUMENT FOR YOUR RECORDS.

[1] ***The Level2 telehealth physician practices include: Level2 Medical Services, P.A. (DE); Level 2 Medical Services, P.C. (AK); Level 2 Medical Services P.C. (CA); Level2 Medical Services, P.A. (NJ); Level 2 Medical Services, P.C. (UT); and any other physician practice that now or in the future becomes an affiliated Level2 telehealth physician practice.***

Rev. 3/16/2023