



Request to Access Medical Record

Please return completed form to the WRMS Clinic

Patient Name: _____

Birth Date: _____ Last 4 digits of your SSN: _____ Phone: _____ Home/Cell/Work

Street Address: _____ City: _____ State: _____ Zip: _____

Please Check the Types of Records to Be Accessed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Consultation | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Operative report | <input type="checkbox"/> EKG | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> ER Record | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Other, Please Specify _____ | | |

Dates of Service:

- All dates of service
 Date of Service From _____ To _____

Delivery of Records:

I request that a copy of my records be delivered to me by the following method:

- In person pick-up
- Mail to _____
 Name of person to whom the records are directed
- Street Address _____ City _____ State _____ ZIP _____
- Fax to _____
- Secure Email to _____
- Other _____

I understand that I am allowed to have access to these records and that, where readily producible, the information will be provided to me in the form and format of my request. I understand that my request must be made in writing and that it may be denied in certain limited circumstances.

I understand that my request will be acted upon within 30 days unless I'm given written notification informing me that an extension of up to 30 days is needed.

I understand that Washington Regional Medical System cannot be responsible for the security of my records once delivered according to my direction.

I understand that personal health information should not be sent via email in an unencrypted file and, although it is my right to request such delivery, I understand that Washington Regional Medical System strongly suggests that I choose an alternate delivery method.

I understand that I will not be charged for this request.

Signature of Patient

Date

If you are acting as a legally authorized representative of the Patient, please complete the section below.

Printed Name of Representative

Relationship to Patient
(parent, legal guardian, etc.)

Signature of Representative

Date