Advantage Primary Care
507 W. Monroe Avenue, Suite A
Lowell, AR 72745
Phone 479-463-8150
Fax 479-463-8151

WashingtonRegional

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:

__Complete Medical Record
__Discharge Summary
__Operative report
__History and Physical
__Other, Please Specify _____

___Consultation
___Pathology Report
___EKG
___ER Record

___Radiology Reports
___Laboratory Tests
___X-rays
___Billing

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 _____