Washington Regional

Washington Regional Medical Records

Mailing Address:
3215 N. Northhills Blvd., Fayetteville, AR 72703

Physical Address:
3318 N. Northhills Blvd., Ste. 110, Fayetteville, AR 72703

Phone: 479.463.1158

Request to Access Medical Record

Please fax completed form to Washington Regional Medical Records at 479.463.1239

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 ___Consultation ___Radiology Reports
__Discharge Summary ___Pathology Report ___Laboratory Tests
__Operative report ___EKG ___X-rays
__History and Physical ___ER Record ___Billing
__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 <DISK ONLY, PAPER RECORDS WILL BE MAILED OR EMAILED>

__ 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 Center 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 Center 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