

PATTIE A. CLAY REGIONAL MEDICAL CENTER
P.O. Box 1600
Richmond, Ky. 40476
Phone (606) 623-3131

REQUEST TO REVIEW/RECEIVE MEDICAL INFORMATION

I, _____, do hereby authorize Pattie A. Clay Regional Medical Center to disclose to _____ information from the health/medical records relating to my identity, diagnosis, prognosis, and/or treatment.

PATIENT IDENTIFICATION:

NAME _____

MEDICAL RECORD # _____

ADDRESS _____

DATE OF BIRTH _____

INFORMATION REQUESTED:

Date (s) admission or treatment: _____

_____ Entire Medical Record-**Excluding HIV/AIDS results**

_____ Emergency Room Record

_____ Face Sheet

_____ Discharge Summary

_____ Operative Report

_____ History and Physical

_____ Pathology Report

_____ Radiology Report

_____ Laboratory Report—**Excluding HIV/AIDS results**

_____ Other (specify) _____

_____ HIV/AIDS Related Information -----Pt. Initial _____

_____ Alcohol/Drug Test Results-----Pt. Initial _____

REASON FOR REQUEST:

_____ External Review

_____ Future Medical Care

_____ Insurance

_____ Legal Claim

PERSONAL IDENTIFICATION PRESENTED:

_____ Social Security Card

_____ Driver's License

_____ School/Work I.D.

_____ Other

I understand that I may **REVOKE** this release at any time, in writing, but the request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first, **EXCEPT** to the extent that action has been taken thereon. I also understand that this release may include medical records of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse.

IF PATIENT IS A MINOR - Are you currently married to the father/mother? Yes _____ No _____. If you checked no, you must provide this office with proof of custody before records can be released.

Signature

Date of Signature

Relationship (if other than patient)

Witness