MEDICAL RECORD REQUEST

Patient Name: ____ DOB: ______________________

Requestor Name: _______________________________ Relationship to Patient: ______________________

Phone No.: ______________________________

Please complete the following information and check all the appropriate boxes

Dates of services associated with request (specific treatment dates or periods) ______________________________

If requesting copies, describe the reason for the request:

- ☐ Coordination of Care ☐ Legal Purposes ☐ Billing ☐ Beneficial Benefits
- ☐ Other (Please specify): ____

Describe the information you are requesting to view or obtain copies:

- ☐ Assessment ☐ Labs ☐ Progress Notes ☐ Medications
- ☐ Other (Please specify): ____

Delivery Method of Records Accessed (if requesting copies of records, please select the delivery method):

- ☐ Pick up the records in person in paper form
- ☐ Mail records to (print name & address): ____
  ____
- ☐ Send records to email (print email address):____
- ☐ Summary of the requested protected health information instead of copies of the medical record.

All requests will be handled within 30 days. For urgent requests, list date here: ____________________

Signature: ____ Date: ______________________

Review of Denial Right: If your request is denied in whole or in part as indicated below, you have the right to request a review of the denial. If you want to exercise this right, complete the *Request for Review of Denial* form and return it to the clinic. A review will be conducted by a licensed health care professional who did not participate in the original decision to deny your request.

Complaint Right: If you have concerns about this procedure, you may file a complaint by contacting PORT Health Services, Attention: Compliance & Privacy Professional, 154 Beacon Drive, Suite I, Winterville, NC 28590.
Telephone: 252-353-1114 Online: https://www.porthealth.org/quality-improvement/grievance

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FOR OFFICE USE ONLY

Determination of Request

☐ Request is approved (Route form to Releases Staff for invoice and copies (if applicable). Upload form in EHR and send with record copies.)

☐ Request is denied ☐ in Whole or ☐ in Part (Upload in EHR and send this form to patient with a 'Request for Review of Denial' form and the accessible records if "in Part" is checked.

Reason for Denial: A licensed health care professional has determined, in the exercise of professional judgment that:

- ☐ The access requested is reasonably likely to endanger the life or physical safety of the patient or another person.
- ☐ The records mention another person (other than health care provider) and release of the information may cause substantial harm to the other person.
- ☐ The request of access to records was made by the patient's legal representative and the release of records to such person may cause substantial harm to the patient or another person.

____ ____________________

Printed Name and Signature of Health Care Professional Date