MR#_____

# WAYNE COUNTY HOSPITAL
# REQUEST TO REVIEW/RECEIVE MEDICAL INFORMATION

**PATIENT IDENTIFICATION**

**Patient Name _____ DOB_____**

**Address _____ Phone No._____**

**_____**

**I, _____, do hereby request to**

**_____review ____receive a copy of medical record information by _____fax, _____email,**

**_____mail, or _____ pick-up**

**The record being requested is of ____self ____child ____other_____.**
**(Specify)**

**Date(s) of Service _____**

**Specific Information Requested**

**____ Discharge Summary ____ History & Physical ____Operative Report**

**____ Lab ____ Radiology ____ Drs. Orders**

**____ Pathology Report ____ Entire Medical Record ____ ER Record**

**____ Other (specify) _____**

**Reason for Request**

**____ Continuity of Care ____ Personal Interest ____ Legal Claims Processing**

**____ Insurance Claims Processing ____ Other (specify) _____**

**Identification Presented**

**____ Driver's License ____Work ID ____ School ID ____ Other (specify)_____**

****Based on KRS 422.317 a first copy of a patient's record will be provided free, subsequent copies may be charged.**

**_____ _____**
**Date (Patient, Parent, or Legal Representative) Please circle**

**_____ _____**
**Date (Witness)**

**Staff Person Receiving Request or Telephone Call: Name _____ Date _____**