MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT: NHCHASNINST 5211.4	ISSUANCE DATE: 20110422
LOCAL FORM TITLE: RECORD REPRODUCTION REQUEST	

NAVAL HEALTH CLINIC CHARLESTON
RECORD REPRODUCTION REQUEST

DATE: _____

PATIENT'S NAME: _____ SPONSOR'S NAME: _____

SPONSOR'S HOME PHONE: _____ WORK PHONE: _____

REASON FOR REQUEST: (CHECK ONE) _____ SEPARATION _____TRANSFER _____PERSONAL _____DOCTOR OTHER: _____

CHECK CORRECT STATEMENT BELOW:

_____ 1. I wish to pick-up my copies personally.

_____ 2. Please mail my copies to the address below by certified mail:

NAME: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

_____ 3. I grant permission for the following person to pick up the copy of my medical record. (Person picking up copy must present written authorization and proper ID along with patient's ID.)

Designated person_____

Note: This office requires a minimum of 20 working days from date of request or return of record from clinic before copies will be ready for pick-up. (Copies not picked up within 30 days of date below will be destroyed.)

I have read and understand all of the above and hereby authorize copying and release of my/my child's medical records in accordance with the privacy act of 1974 and HIPAA Law.

X_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE WITNESS

PATIENT/GUARDIAN REQUEST THE FOLLOWING PART OF THE MEDICAL RECORD BE COPIED: (CHECK ONE)
_____ LAST _____ YRS _____ LABS/RADS ONLY _____ FROM _____ TO PRESENT

SPECIFICS_____

EARLIEST DATE PATIENT/GUARDIAN DESIRES TO RECEIVE COPY: _____

IN LOG BOOK_____CHARGED OUT_____OUTGUIDE ON SHELF_____COPY MADE_____ INITIALS/DATE_____

This information is protected by the Privacy Act of 1974 (PL-93-579) and
the Health Insurance Portability and Accountability Act (PL 104-191)

PRACTITIONER'S/NURSE'S NAME	PRACTITIONER'S/NURSE'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	