Patient Name __________________________ MPI# __________________________

Requestor’s Name ___________________________ Relationship to Patient

Purpose of Disclosure
(See Also: Authorization For Use And Disclosure Of Protected Health Information form (CVH-184) completed by requester)

Requested Information:          [ ] Entire Record          [ ] Abstract of Record to include:
[ ] Admission/Annual Assessments
[ ] Psychiatric and/or Psychological Exam
[ ] Discharge Summary

[ ] Other

Additional Comments/Concerns:

Dr. __________________________, the above named patient, or other interested party as stated above, is requesting a copy of documentation in the medical record of the above listed patient. Please record your decision below and return this form to the Medical Record Department.

[ ] NO Request for copies of the medical record document(s) listed above is DENIED. The Medical Record Department will notify the patient/requestor of your decision and will advise them of their right to have a physician of their choice review their request.

REASON for denial of request:

[ ] YES I authorize that this patient/requestor may receive the above listed document(s). The Medical Record Department will process request.

[ ] APPOINTMENT necessary with the patient/requestor to further evaluate the request. The Medical Record Department will arrange an appointment for you with the patient/requestor.

Physician Signature __________________________________________ Date ___________________