REQUEST FOR REVIEW OF MEDICAL RECORDS

Case # ____________________

DATE OF REQUEST

NAME OF PATIENT | MEDICAL RECORD NUMBER | DATE OF BIRTH

ADDRESS OF PATIENT | LOCATIONS OF RECORDS TO BE REVIEWED

NAME OF REVIEWER / COPY SERVICE | TELEPHONE NUMBER | Firm/ Copy Service

REPRESENTING (NAME OF INSURANCE: COMPANY OR ATTORNEY IF DIFFERENT THAN REVIEWER) | PHONE NO

THIS REVIEW IS REQUESTED FOR THE FOLLOWING REASON:

1. ☐ LIABILITY CLAIM OR LAWSUIT (PATIENT CLAIMING VS. PARTY CAUSING INJURY) DATE OF ACCIDENT ____________
2. ☐ WORKMAN'S COMPENSATION CLAIM (INJURY AT WORK) DATE OF ACCIDENT ____________
3. ☐ OTHER INSURANCE CLAIM (DISABILITY MEDICAL REIMBURSEMENT) ____________

Facility is to produce any and all records, not only records pertaining to *date of* injury.

4. ☐ REVIEW FOR OUTSIDE DOCTOR
5. ☐ PHOTOSTATS (STATE REASON) ____________
6. ☐ OTHER (EXPLAIN) ____________

MED. DIRECTOR OR PHYSICIAN | DATE | HOSPITAL ADMINISTRATOR | DATE

INSURANCE DEPARTMENT | DATE | MEDICAL RECORD LIBRARIAN AND/OR CHART ROOM SUPERVISOR | DATE

SIGNATURE OF REVIEWER | DATE

PATIENT'S SIGNED AUTHORIZATION RECEIVED.
REVIEWER'S CREDENTIALS CHECKED BY: ____________

NOTE: NO RECORD MAY BE INSPECTED WITHOUT THE FOLLOWING:

(1) PROPERLY EXECUTED AUTHORIZATION BY PATIENT IN ALL CASES
(2) AUTHORIZATION OF MEDICAL DIRECTOR OR PHYSICIAN IN ALL CASES
(3) INSURANCE DEPARTMENT IN ALL CASES
(4) HOSPITAL ADMINISTRATOR - HOSPITAL PATIENTS
(5) MEDICAL RECORD LIBRARIAN - HOSPITAL PATIENTS
(6) CHART ROOM SUPERVISOR - CLINIC PATIENTS