

_____ ANGEL MEDICAL CENTER
P.O. Box 1209
Franklin, NC 28744

_____ ANGEL URGENT CARE
195 Franklin Plaza
Franklin, NC 28734

MR# _____
ACCT # _____

**PATIENT/LEGAL REPRESENTATIVE
REQUEST FOR ACCESS TO HEALTH INFORMATION**

Name: _____ Date of Birth: _____

Telephone #: work _____ home _____

Address: _____

Access Requested: pick up copies mail copies inspect medical information

Information Requested: Medical Record Information

Dates of Service: _____

___ Standard information (includes discharge summary, H&P, op note, consult, ER, lab & x-ray)

___ Discharge Summary ___ ER Record ___ Lab Report ___ X-Ray Report

___ Operative Report ___ Pain Clinic Notes ___ EKG ___ X-ray Film

___ Other _____

I understand that if my request for access is granted, I will be contacted to arrange for a time and place to inspect my medical information, if applicable. In most cases, this request will be processed within 30 days.

I understand that a fee for copies and/or postage may be charged.

_____ Date

_____ Signature of Patient or Representative

_____ Representative's authority to act on behalf of the patient

For Hospital Personnel Use:

Identity/Authority Verified _____

Date received _____ Date Processed _____

___ person known to me ___ verification of signature ___ verification of photo ID ___ other ID

Staff initials _____