

REQUEST FOR REVIEW OF MEDICAL RECORDS

Case # _____

NAME OF PATIENT _____ MEDICAL RECORD NUMBER _____ DATE OF REQUEST _____
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 _____ DATE _____
AND/OR CHART ROOM SUPERVISOR _____
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