

Request Received: Date: _____ Time: _____ MR# _____

FAX REQUEST for MEDICAL RECORDS

To:
Medical Records
Cookeville Regional Medical Center ("CRMC")
1 Medical Center Boulevard
Cookeville, TN 38501
Phone: 931-783-2625; Fax: 931-783-2627

Patient's Full Name: _____

Date of Birth: ____/____/____

Social Security No: ____-____-____

CRMC Medical Record Number: _____

From:

Your Name: _____

Date/Time of Request: ____/____/____ am/pm

Health Care Provider: _____

- CRMC Medical Staff Member
 - Check here if Provider is **NOT** a covered entity under the HIPAA Privacy Rule. In this case, patient authorization may be required.

Phone Number (_____) _____

When Information is Needed:

- Patient Care Emergency ! Need **STAT!** Urgent—patient or doctor is present and waiting.
 As Soon as Possible By a Specific Date: ____/____/____
(This information is gathered to prioritize requests and attempt to meet customer needs. It does not guarantee that CRMC can meet all requested timeframes.)

Please Describe the Information to be Released (Mark All That Apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Facesheet | <input type="checkbox"/> Copy of Insurance Card | <input type="checkbox"/> Imaging Films/Studies |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Abstract of Key Reports | <input type="checkbox"/> Progress Notes by Doctor _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> X-Ray/Imaging Reports | _____ |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Complete Chart | _____ |

For the Following Date(s) of Service: _____

Please Send Information Via:

Mail **Address:** _____

Fax **Fax Number:** (_____) _____
(Ensure that fax machine is accessible only by authorized individuals.)

Put in CRMC Physician Mailbox for Pick-Up or Delivery by Courier

Purpose of Disclosure:

- Treatment ("Minimum necessary" does not apply.)
 Payment or Billing Purposes
 Operations - *for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:*

*(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or
(ii) For the purpose of health care fraud and abuse detection or compliance.*

Other: _____