CVH-151
Rev. 4/03

CONNECTICUT VALLEY HOSPITAL
REQUEST FOR COPY OF MEDICAL RECORD DOCUMENTATION

Name _____ Unit _____

I am requesting a copy of the following documentation be released from my medical record:

1. _____

2. _____

3. _____

4. _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

SEND COMPLETED FORM TO: HEALTH INFORMATION MANAGEMENT

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Date:_____

Dr. _____ , the above named patient is requesting a copy of documentation in their medical record. Please record your decision below and return this form to the Health Information Management.

[ ] **NO** Request for copies of the medical record document(s) listed above is **DENIED. A progress note must be written in the patient's medical record detailing your reason for denial.**
Please complete the "Denial of Access to Your Medical Record" form (CVH-184d) which will notify the patient of your decision and will advise them of their right to have a physician of their choice review their request.

[ ] **YES** I authorize that this patient may receive the above listed document(s).
Health Information Management will process request.

_____ _____
Physician Signature Date

RECEIPT OF INFORMATION:

I, _____ understand that the above listed information is being released to me under provisions of the Connecticut General Statutes. I assume responsibility for the confidentiality of these documents and Connecticut Valley Hospital is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Received by: _____ Date Received _____

Date Processed: _____ By (initials): _____

ORIGINAL - Medical Record COPY - Patient