Bryan GRAND ISLAND Regional Medical Center

Medical Records Request

Patient Name: ______________________________ Date of Birth: ________________

Address: __________________________________ Phone: ____________________

City, State, Zip: ____

Information Requested:

- ☐ Labs/Pathology Reports
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Progress Notes
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultation/Clinic Note
- ☐ Billing/Claim Forms
- ☐ Entire Medical Record

Dates of Service for Records Requested: ______________________________________

Special Release Requested:

☐ Mental/Behavioral Health Notes ☐ HIV/AIDS testing ☐ Alcohol/Drug use, abuse, treatment

Initials: __________ **Date:** ________________

Purpose of Disclosure:

☐ Personal ☐ Insurance ☐ Legal ☐ Continuity of Care

Recipient Information:

Name: ____ Phone: _______________

Address: ____

Fax: __________________ Email: ___________________________________

My completion of this form serves as authorization for Grand Island Regional Medical Center (GIRMC) to disclose the specified records to the above listed person or group. I understand that once my information leaves GIRMC, GIRMC is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Requestor Signature: ____

Printed Name: ____

Relationship to Patient: _________________________ Date: ________________

Office Use Only: Requestor Identification Verified

Initials: ______________ Date: ____________