REGIONAL MEDICAL CENTER

3000 St Matthews Road
Orangeburg, SC 29118
Phone: 803-395-2272 Fax: 803-395-4011

REQUEST FOR ACCESS TO HEALTH INFORMATION

PLEASE COMPLETE SECTIONS A – E

A

NAME		PATIENT NUMBER
ADDRESS		
CITY	STATE	ZIP
PHONE	FAX	E-MAIL

B

REQUEST IS FOR:	
❑ Copy of health information	❑ Amendment of health information
❑ Access to health information	❑ Accounting of disclosures of health information

C

COPY OR ACCESS TO HEALTH INFORMATION	
Information requested: _____ _____ _____ _____	Please select appropriate format: ❑ Paper copy ❑ Review only ❑ Other, please describe_____ _____ _____

D

AMENDMENT – PLEASE DESCRIBE REQUESTED CHANGE
_____ _____ _____ _____ _____

E

AUTHORIZATION TO PROVIDE	
PATIENT SIGNATURE	DATE

To be completed by provider personnel

DISPOSITION	
❑ Request granted	❑ Request denied
Reason for denial_____ _____ _____	

SIGNATURE	DATE

Form written 10/8/02 bdg; Revised 10/09/08 jmc

Attachment to VIII-07