Paragould Family Care, PA
5 Market Pl | Paragould, AR 72450
Phone: (870) 236-4001 | Fax: (870) 236-4009

Patient Request for Medical Records

Patient Name: ____ Date of Birth:______________

Phone Number____________________ Last Four Digits of Social Security Number:___________

Address____

Email Adress____

As the patient, or the patient's personal representative, I am requesting a copy of the medical record held by Paragould Family Care, PA.

Date(s) of Service Requested: ____

_____ Summary of Medical Record
_____ Entire Medical Record
_____ Radiology
_____ Laboratory
_____ Operative/Pathology Report
_____ Immunization Records
_____ Other Information: ____

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

I request the record to be provided in the following format:

_____ paper _____ CD _____ secure portal _____ fax ______ unsecure email

I understand if I request the record to be provided by email that I undertake the following potential risks:

- The information may be obtained by someone else
- The information can be opened and read by someone else
- Unencrypted information does not provide any assurance of privacy or security

____ ______________________
Patient Signature Date

____ ______________________
Legal Representative, if not patient Date