HORN AND ASSOCIATES IN REHABILITATION, PLLC

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Medical Records Request Form

Patient Name: ________________________________

Patient Date of Birth: ________________________________

Requested by: Patient [ ] Other [ ]________________________

Dates of service: ________________________________

Records you are requesting: ____

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Delivery Method:

Email [ ]________________________________

Fax [ ]________________________________

Pick up [ ]

Pursuant to KRS 422.317, patients are entitled to one free copy of their medical records. Any additional copies will be subject to the office records request rate at that time.

___________________________________ ________________

Signature Date

Please email this form to info@horntherapy.com or fax to 859-224-4082 and attach a copy of your photo ID to verify your identity. Our office can take up to 2 weeks to process your request.