



HORN AND ASSOCIATES IN REHABILITATION, PLLC

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Medical Records Request Form

Patient Name: _____

Patient Date of Birth: _____

Requested by: Patient [] Other [] _____

Phone Number: _____

Dates of service: _____

Records you are requesting: _____

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.