CRAVEN COUNTY HEALTH DEPARTMENT
Working Together For Your Health
CRAVEN COUNTY COMMUNITY HEALTH CENTER

MEDICAL RECORDS REQUEST

The cost of copying my medical records has been explained to me **($10 for the first 20 pages and $0.25 for**

each page thereafter).

The possibility of the information being seen by an outside party or being lost is now my responsibility.

I understand that the **Craven County Health Department** is **not** responsible for the integrity and confidentiality of the copy of the medical record in my possession.

I waive the opportunity to review my medical record, ask questions, answer any concerns and/or explain test results currently before the copies are released to me.

Specify information to be disclosed : _____

For the specific purpose (s): _____

SIGNATURE: _____

Patient/Parent/Legal Guardian **Personal Representative

Date: _____ Telephone #: _____

*Designation of Personal Representative (if applicable): _____

Witness: _____ Date: _____

Interpreter and Language used (if applicable): _____

For Office Use only_____

Cost determined after processing $_____

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