Cayman Islands Health Services Authority
P.O. Box 915, George Town, Grand Cayman
Tel: (345) 949-8600 Fax (345) 949-0156

HSA

Health Information Management

Medical Information Release Request Form

Patient Name (Print in Full) _____

Birth Date: _____

Home Telephone: _____

Work Telephone: _____

Please note that:

1. *Copies may take 5-7 days to process and allow 15 days processing for Medical Reports.*
2. *There is a fee for all copies and reports.*
3. ***Proof of identification is required before any information is released. .***

I require this information for the following purpose(s):

☐ Local Referral	☐ Overseas Referral	☐ Legal Purposes
☐ Employment	☐ Insurance	☐ Immigration Medical
☐ School Medical	☐ Social Services	☐ Other – specify:_____

I require:

1. **Entire File** for period _____to _____

   (this includes Labs, Radiology, and Doctors Notes)

2. **Copy Only**

   ☐ Lab Results ☐ X-ray Reports ☐ Doctors Notes

   for the period: _____ to _____(date/s)

3. **Medical Report**

   Please specify: ☐ General medical report ☐ Report of specific injury or illness

   Other information: _____

The information needed is to be:

☐ Mailed to: _____

☐ Faxed to: _____

☐ Will be picked up by: _____

I waive all responsibility of the Cayman Islands Health Services, regarding the confidentiality of information released to the aforementioned party.

Signature of Patient or Guardian: _____

If Guardian, specify relationship to patient: _____

Identification # (Valid I.D. / Passport / Drivers license) _____

Witnessed by Medical Records Personnel – Signature Date: _____

Office Use Only

Authorization given to release information from patient record by:

Medical Director: Physician

HIM Manager: Date Mailed / Faxed / Picked Up: