HEALTH SCIENCE CENTER
TEXAS A&M UNIVERSITY

ACCESS RECORD FORM

To be placed in the patient's medical or billing record.

Patient Name:_____

Patient Identification Number:_____

DATE THE REQUEST WAS MADE:	
DATE THE REQUEST WAS RECEIVED:	
NAME OF PERSON/ENTITY MAKING ENTRY:	
PORTIONS OF THE DESIGNATED RECORD AFFECTED:	
STATUS OF THE REQUEST: • Accepted – in whole/in part • Denied – in whole/in part • In Process	
DATE OF STATUS ENTRY:	
REFERENCES TO ANY CORRESPONDENCE:	
OTHER COVERED ENTITIES WHICH WILL BE AFFECTED BY DECISION:	
BUSINESS ASSOCIATES WHICH WILL BE AFFECTED BY DECISION:	
COMMENTS:	