

Clinical Records and Resident Access – Form/Questionnaire

Your Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail address: _____ Home Phone: _____

Business Phone: _____ Additional: _____

Name of party at nursing home (if different than above): _____

Relationship to party at nursing home (if applicable): _____

Name of Nursing Home: _____

Address of Nursing Home: _____

City: _____ State: _____ Zip: _____

Please complete the following to the best of your ability:

Approximately how many reside at this facility?

- 10 or fewer
- 10 – 50
- 50 – 100
- greater than 100

What is the approximate number of staff?

- 10 or fewer
- 10 – 50
- 50 – 100
- greater than 100

Upon admission, was the resident informed of his or her rights at the facility?

- Yes
- No

If “yes,” was this notice in writing?

- Yes
- No

Upon admission, was the resident informed of the facility’s responsibilities and services?

- Yes

No

If "yes," was this notice in writing?

Yes

No

Have you (or the resident) ever requested his or her clinical records?

Yes

No

If you (or the resident) have requested his or her clinical records, were you allowed access to them?

Yes

No

If you (or the resident) have requested his or her clinical records, were you able to photocopy them?

Yes

No

Additional comments or concerns:
