Medical Records Release

Please Print Clearly & Fill-in All Sections Completely

Patient's Name:____ Date of Birth:_____________________

Address:____ Last Four of SSN:_________________

I authorize Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio custodian of my medical records to disclose/release the following information* (check all that apply)

❑ All records ❑ Operative Reports ❑ Progress Notes ❑ X-ray/radiology records

❑ Billing records ❑ Other____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing the disclosure of this information.

These records are for services provided on the following dates: ____

Please send the records indicated above to:

Name:	______________________	Name:	______________________
Address:	______________________	Address:	______________________
	______________________		______________________
Phone:	______________________	Phone:	______________________
Fax:	______________________	Fax:	______________________

<u>The information being requested is for (please mark all that apply):</u>

❑ Second Opinion
❑ Specialist Care
❑ Permanent Transfer of Care

❑ Legal (Specify)_______________________________________
❑ Temporary Transfer of Care (Indicate Dates)_____________
❑ Other (Specify)_______________________________________

This authorization is valid for one-hundred-eighty (180) days from the date it is signed. I understand that after the custodian of records for Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio discloses my health information, it may no longer be protected by federal privacy laws. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. I may revoke this authorization in writing, at anytime. I understand that a revocation of this authorization has no effect on records that have already been disclosed in response to authorizations received prior to the written notice of revocation. Written revocation is effective upon receipt by the Medical Records Department of Orthopedic Associates of SW Ohio. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_______________________________________ _______________________________
Signature of patient (or patient's representative) *Date*

_______________________________________ _______________________________
Printed name of patient or patient's representative *Representative's authority to sign for patient (i.e. parent, guardian, power of attorney for healthcare)*

All records will be mailed by Healthport to address listed above. Please allow two weeks for completion.

OASWO Witness:_______________

Tips for Receiving Medical Records Promptly

1. Please fill out the attached form completely, leaving no blanks.
2. Please print clearly!
3. Fax numbers CAN NOT be used
4. The "Send Records To:" area must be filled out with a complete mailing address.
5. Charges for Records
a. There will be a charge for any records requested by a patient to be mailed directly to the patient (see the below Fee Schedule)
b. There is no charge for records sent to a physician's office
c. Requests for/by attorneys, insurance companies, disability claims, SSI are charged to the requestor.
6. Requests are processed by Healthport; Please allow 14 business days for all requests to be completed

Fee Schedule

1-10 Pages $2.88
11-50 Pages $0.60 per page
51+ Pages $0.24 per page
Postage as required
Data record other than on paper: $1.97 per page