HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (Advanced Pain Diagnostic & Solutions)

MRN

Facility Use Only

Please PRINT and fill out entirely.

Patient Information

Patient Name: _____ / /
Last First Middle (any previous name) Date of Birth

Patient Street Address City State Zip ( ) Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: Attention:

Address City State Zip

( ) ( )
Phone Fax Email Address

Method of Purpose Release

Person/Place requesting records (check all that apply):
0 Patient/Parent/Legal Guardian **0** Doctor/Hospital **0**Lawyer **0** Insurance Company **0** Other

Purpose of Release (check all that apply):
0 Patient Care **0** Disability **0** Insurance **0** School **0** Legal **0** Personal Use **0** Other

Format of records to be released:
0 on paper **0** PDF [on CD or Jump Drive (if available)] **0** Verbal communication only with person or agency listed above

Information May Be Sent Via: (*Note: Radiology images can only be placed on CD and mailed or picked-up)*
0 Mail Delivery **0** Fax **0** Pick Up **0** Encrypted Email* **0** to MyChart* (*electronic records only, size restrictions apply)

Information to Release

Dates of Treatment Requested: _____ (If not specified, the **LAST 6 MONTHS** will be released)

0 Medical Record Abstract – pertinent information generally used for continued care/personal use/disability.
The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, History & Physical, Inpatient Consult, Emergency Record Report(s), Operative Report(s), Radiology Reports, Lab or Other Tests

Other Information Requested (choose any to release):
0 Billing Records
0 Radiology Reports **0** Misc:_____
0 Radiology Images on disc **0** Misc:_____
0 Lab results (blood work)
0 Appointment List
0 Demographic Page

0 Doctor's Office Reports _____

0 Other: (please list exact documents) _____

Patient/Parent/Legal Guardian

This authorization expires **one year** from the date of signature, OR on this date / event:

I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, to Advanced Pain Diagnostic & Solutions.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

/ /
Signature of Patient or Parent/Legal Guardian(Printed) **Name** **Date**

My relationship to the patient is ( ) Self ( ) Parent ( )gal Guardian – Attach Court Order to show your authority to sign

/ /
Signature of Witness **Printed Name** **Date**

Submit

Submit **completed form** AND a **copy of a valid Photo ID (if a current one is not on file with us)** to:

Mail form to:	**Fax** form to:	**Email** form to:	**Questions? Call**:
Advanced Pain Diagnostic & Solutions 729 Sunrise Ave Ste 602 Roseville, CA 95661	916-860-7854	medicalrecordsgroup @apdss.com	916-953-7569

Tips for Requesting Medical Record Copies – DID YOU KNOW?

Who Can Request Records:

- Patient (if 18 years of age or older, or a minor if the minor had authority to consent to their treatment)
- Biological Mother
- Biological Father married to biological mother at time of patient's birth
- Under California law, all other persons must provide documentation from the Court to show their authority to request records.

What Records Should I Request?

- If the information requested is for continuing patient care, patient/parent/legal guardian use, or disability purposes the receiving entity generally only wants a **Medical Record Abstract** (see definition below) of pertinent information.
- When requesting dates of service, a **Medical Record Abstract** of the medical records from the last 6 months of active treatment will be released, unless otherwise specified. If additional records are needed, please specify dates.

- Requests for "**ALL**" information (which includes for example: progress notes, nurses notes, flowsheets, consent forms, etc.) can considerably delay processing of your request and become very costly. If you need assistance determining what to request, please ask the person/entity authorized to receive the information what they need, or contact a Health Information Management (HIM) Department representative at 916-953-7569, and we will be happy to assist you.

Medical Record Abstract contains the following documentation:

Discharge Summary From an Inpatient stay, this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay

Emergency Record This record documents a summary of the care, treatment and services provided for a visit to the emergency room

History & Physical This form details the present illness or care needs and denotes any relevant past history

Inpatient Consultation Report(s) This report documents the findings of a physician asked to examine a patient during an inpatient or observation stay

Operative/Procedure Report(s) This report details the surgeon/proceduralist's findings, technical procedures used, specimens removed and postoperative diagnosis

Outpatient Clinic Note(s) Notes from outpatient office/therapy visits

X-Ray Reports, Labs or Other Tests Radiology, lab results, and other tests

Fees and Format: Paper records sent to patient/parent/legal guardians or to providers for continuing patient care, are **not** charged. If you request a CD or if records are being sent to another person/entity, there may be a charge. See below:

Paper Copies $25.00 or on CD $25.00
Radiology Images $10.00 for 1st CD, then $4.00 for each additional CD.

- If you've selected **"Reviewed in HIM**," an appointment needs to be scheduled. An HIM Department representative will contact you when the records are ready to be reviewed.

How Long Will it Take? The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers **30 days to process records** requested by patients/parents/legal guardians. If we need more time to process your request, we can take another 30 days if we notify you that additional time is needed. Advanced Pain Diagnostic & Solutions to provide records more timely, however, occasionally the full 30 days are required.

Can My Request be Denied? Yes, some records may need to be reviewed prior to release and your request could be denied. Under federal and state law.

I How Do I Request Medical Records? To request medical records, you must complete a **HIPAA Authorization to Release Medical Records Form.** This form may be found on our website: WWW.APDSS.COM The bottom of the form details different ways to submit the Request for Information. When you submit this form, you must also submit any documentation that is required to show your authority to request records (see "Who Can Request Records" above). If documentation is required, your request cannot be processed if you do not submit documentation of your authority to request records.