MEDICAL RECORDS RELEASE

Please Print Clearly & Fill-in All Sections Completely

Patient's Name:_____ Date of Birth:_____

Address (street, city, state & zip code: _____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 Protected Health Information: (please check all that apply)

☐ All records ☐ Operative Reports ☐ Progress Notes ☐ X-ray/radiology records ☐ Billing records

☐ Other_____

OR: Release ONLY the specific dates of service as listed: _____

*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.

Please send the records indicated above to:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

The information being requested is for (please mark all that apply):

☐ Second Opinion ☐ Legal (Specify)_____

☐ Specialist Care ☐ Temporary Transfer of Care (Indicate Dates)_____

☐ Permanent Transfer of Care ☐ 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 MediCopy to address listed above.
For medical records please allow 30 days for completion, for FMLA/Disability please allow 7-10 calendar days for completion.

Signature OASWO Witness: _____ Date: _____

Printed name of OASWO Witness: _____

(Revised 1/11/19)

Tips for Receiving Medical Records Promptly

1. Please fill out the attached form completely, leaving no blanks. Please make sure your complete address is noted on the request including the street, city, state, and zip code.

2. Please print clearly! Do not scratch or cross anything out.

3. The "Send Records To:" area must be filled out with a complete mailing address, telephone, and fax numbers.

4. Charges for Records:
    a. There will be a no charge for records requested by the patient.
    b. Requests for/by attorneys, insurance companies, disability claims etc. are charged to the requestor.

5. Requests typically take 3-5 business days to process, but please allow up to 30 days.

6. If the "All" records box is checked, then all records will be sent to the requestor. If the release indicates a specific time period or specific dates where noted in bold print on the authorization, i.e. OR: Release ONLY the specific dates of service, then ONLY those records can be sent to the requestor. This is due to HIPAA rules/regulations. If both the "All" records and specific time period boxes are checked, then only the records from the specific time period will be forwarded to the requestor.

7. If the requestor requires billing information, the "billing" box must be checked in order for the information to be released.

8. Records CANNOT be Emailed, please include a Fax number to where records should be sent. If only an address is provided records will be mailed.

9. If you need Images, please note that you need these otherwise only reports will be provided. Images will be provided on a disc and can either be picked up or mailed.

Fee Schedule

Please note all charges for copies for Medical Records follow the Current fees allowed by the Ohio Revised code sections 3701.74, 3701.741, and 3701.742, any actual cost of related postage incurred by the health care provider or copy service will also be charged at actual cost as allowed by law.