MediCopy Authorization for the Release of Medical Records

Tell us about the patient.

Name: DOB:

Email: MRN:

Address:

City: State: Zip:

Phone#: Fax#:

Where are the records being released from?

Facility Name: Provider Name(s):

Address: City: State:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released? Check all that apply.

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ Pathology Results

☐ Radiology Images ☐ Radiology Reports ☐ Immunization Records ☐ Labs

☐ Last Two Years of Records ☐ Consultations ☐ Dates _____ to _____

☐ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ Continuation of Care ☐ Transfer to New Physician ☐ Personal Use

☐ Litigation ☐ Insurance

Delivery Method: How would you like the records sent

☐ Email ☐ Fax ☐ Pick Up At the South Bend Clinic HIM ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 60 days from the date of signature unless otherwise specified. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient: Expiration date (60 days, if not specified):