REQUEST FOR RELEASE AND DISTRIBUTION OF PROTECTED HEALTH INFORMATION PURSUANT TO 45 CFR § 164.508 AND 42 U.S.C. § 17935(e)(2)

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

RE: Patient Name: _____

Also known as: _____

Date of Birth:_____ Social Security Number: _____

I, _____ request the retrieval and delivery of all protected information herein requested for my personal use and benefit (at the request of the individual). I expressly request and direct that the designated custodian of records of each, every, and all covered entities under HIPAA identified above disclose full and complete protected medical information; that is, each, every, and all ***complete designated record set(s)*** (see 45 C.F.R. § 164.501) including, but not limited to, the following:

All medical records, meaning every page in my record, including but not limited to:

Office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records,discharge summaries, requests for and reports of consultations, documents,correspondence, test results, statements, questionnaires/histories, correspondence,photographs, videotapes, telephone messages, and records received by other medical providers;

All physical, occupational, speech, and rehabilitation therapy requests, consultations and progress notes;

All disability, Medicaid or Medicare records including claim forms and record of denial of benefits;

All employment, personnel or wage records;

All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and images or films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram, electrocardiogram, implanted device interrogations reports with all captured tracings, cardiac catheterization reports or results, videos/CDs/films/reels and reports;

All pharmacy/prescription records including NDC numbers and drug information handouts/monographs provided me by your facility;

All billing records including all statements, insurance claim forms, itemized bills including ICD and CPT codes, and records of billing to third party payers and payment or denial of benefits for the period identified below;

A list of all business associates providing care, accessing the medical record, conducting assessments, surveys, or interviews or otherwise contributing to the designated record set during the dates herein described and specified for whom the above named covered entity does not perform billing services;

A complete and detailed listing of information associated with the creation and maintenance of the Electronic Health Record (EHR) and designated record set identified in the HITECH Act (45 C.F.R. § 164.312(b)) as the Audit Control, and sometimes referred to elsewhere as the Audit Trail, metadata, or by any other designation wherein such information details each and every individual or entity access of these records, changes made thereto, or reviews of the information contained therein to demonstrate the integrity of the record (see 45 C.F.R. § 164.312(b));

You are instructed to provide statutorily required audit controls in conjunction with all electronically stored information (ESI) related to my encounters with you or your organization at each and every facility during the time period elsewhere specified in this request to include, though not be limited to: my entire and complete electronic health records (EHRs), including but not limited those maintained on the following systems: EPIC, OBIX (fetal heart rate tracings), CO-PATH (pathology), PACS (radiology), CPACS (Cardiology PACS) and other systems or software for tracking orders, medications or the results of laboratory studies or testing.

Ensuring that the above requested information be provided for all dates beginning:

_____ through the expiration of this request upon request of the authorized recipient identified below.

PLEASE NOTE: If you are unable to provide any of the above requested information, or are unable to do so within the statutory time limit of 30 (THIRTY) days from receipt of this notice (see 45 C.F.R. § 164.312(b)) you are directed to provide a written explanation of the reason for any such delay or inability to comply as well as the contact information for the appropriate individual or facility able to fulfill the request.

I understand the information to be released or disclosed additionally may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol or immunodeficiency substance abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 C.F.R. § 2.31, the restrictions of which have been specifically considered and expressly waived as indicated by my initials below.

Initials:_____

This is NOT a request for printed electronic medical records. Where there are portions of the records requested stored only in hard copy format and not copied to a digital storage medium, please notify the entity herein identified within 3 **(THREE)** days of receipt of this request to arrange for alternative retrieval options. This is a request for digital files containing the requested records. Please provide the requested records in Adobe Acrobat Portable Document Format (pdf). The provided Adobe Acrobat file of records must be accessible in such a manner as to permit extraction of or redaction of pages to permit me to limit disclosure of information to others providing services where only limited information from this record set is necessary. Please provide all imaging studies in their native format with the appropriate viewer software included to permit access to these images (see 45 C.F.R. § 164.524(b)(2)). You are authorized and directed to, within 30 (THIRTY) days of receipt of this request (see 45 C.F.R. § 164.524(b)(2)(i)), release the above records to the entity identified below who have agreed to pay reasonable charges based upon actual labor and supply costs (per 45 C.F.R. § 164.524(c)(4)(i)-(iii) and 42 U.S.C. § 17935(e)(2)) to supply copies of such records.

If pre-payment is required; please provide me, within 3 (THREE) business days, an invoice through the entity identified below via email or facsimile. Please note that, pursuant to federal regulations and statutes (see per 45 C.F.R. § 164.524(c)(4)(i)-(iii) and 42 U.S.C. § 17935(e)(2)), maximum fees for the provision of these records is limited to the actual cost or average cost of production or the permissible alternative minimum amount. Any invoice should include a detailed cost summary itemizing the wages paid the employee(s) retrieving the requested records or the itemized costs billed by a business associate fulfilling this

request. To reduce your facility expense, return packaging and digital media are enclosed with this request or files may be transferred by SFTP via a SSH shell directly to the entity named below:

Details of these guidelines are shared only with individuals having executed a Mutual Non-disclosure Agreement with MarGin Consulting.

Address per
MarGin-Consulting
Guidelines

Telephone: (999) 555-1212
Facsimile: (888) 555-1212
Electronic Mail: MarGin-Consulting-Guidelines

I, _____ understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. (See CFR §164.508(c)(2)(i-iii))

Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until four years from date of execution at which time this authorization expires.

I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form.

Patient/Personal Representative

Signature: _____ Date: _____

Notarial Acknowledgement

State of Document Execution County of Document Execution

I,_____, a Notary Public for said County and State, do hereby certify that_____personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the_____day of_____, 20 ____.

(Official Seal)

_____

Notary Public

My Commission Expires _____, 20 ____.