Medical Records Request Form

CAPITAL ORTHO

Authorization to Disclose Protected Health Information

The undersigned authorizes *Capital Ortho* to release my health information as noted below.

Phone: 601-987-8200 Fax: 601-586-0590

Patient Information

Patient Full Name: _____ **Date of Birth** _____ **Last 4 SSN:** _____

Patient Address: _____ City: _____ State: _____

Zip: _____ Phone #: _____ E-Mail: _____

Release Information To

Name/Facility:_____ **Attention:**_____

Address:_____ City:_____ State:_____

Zip: _____ **Phone:**_____ **Fax** #: _____

Purpose Of Request

_____ Personal _____Treatment _____Legal _____Insurance _____Transfer _____Other

Information to be Released

___ Please release a **1 year abstract** of my records (includes: office notes, labs, procedures & testing)

___ Please release a **2 year abstract** of my records (includes: office notes, labs, procedures & testing)

___ **Date Range**:_____

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical
□ Therapy □ Billing Statements □Other: _____

___**Radiology Disc**

(**Please pick ONE delivery option**)

[ ] Records on CD	[ ] Fax to Doctor	[ ] Records on Paper

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Mississippi State Law Statute: 11-1-52

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(*Please Initial)*

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**_____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: _____ **Date:** _____

*For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If the patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.

Updated: March 2023