Medical Records Release Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Medical Service Company may verify your identity/ guardianship. Some requests may be subject to a reasonable fee.

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Release Information

What information are you requesting? *(Mark all that apply)*

Date(s) of service: _____

- ☐ Inpatient Abstract (includes face sheet, patient communication notes)
- ☐ Physical / Occupational Therapy Reports
- ☐ History/Physical Exam
- ☐ Sleep Study / Interpretation
- ☐ PAP Compliance Reports
- ☐ Billing (Claim) Information
- ☐ Other: _____

Third Party Disclosures

Person(s) or Medical Provider(s) to whom protected health information (PHI) should be released if other than self. ***If requesting for personal use, indicate NA.***

Name: _____ Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I want the requested medical records to be sent to the third-party (for example, an employer or a school). My completion of this form serves as authorization for Medical Service Company to disclose these records to this person or group. I understand that once my information leaves Medical Service Company, Medical Service Company is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

How do you want these records released?

☐ Fax to the following number: _____

☐ Encrypted E-mail to address: _____

☐ Hard copy sent via USPS to the following address:

Street Address: _____

City: _____ State: _____ Zip Code: _____

☐ Other: _____

Terms of Authorization

I understand this authorization may be revoked in writing at any time, according to the instructions Medical Service Company of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here: _____. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that HIPAA laws allow for Medical Service Company to charge a patient a reasonable fee for the right to access protected health information. These fees include for such items as the cost of copying, supplies, labor, and postage. The current charge is $1.50 per page for the first 10 pages, and then $0.75 for pages 11-500. These cost limits apply to both electronic and paper copies.

I understand that HIPAA laws allow a processing time of up to 30 days to process a request for medical records. However, Medical Service Company tries to complete this process within 7-10 business days after receipt of this form.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

Please print, complete and mail or deliver completed forms to:

Medical Service Company
PO Box 74531
Cleveland OH 44194-4531

Billing@medicalserviceco.com

If you are unable to complete or return this form, please contact Bonny Jones at bjones@medicalserviceco.com for further assistance.