OIO Orthopaedic Institute of Ohio

Release of Medical Records/ Authorization to Disclose PHI

Patient Name_____ DOB_____/_____/_____ SS # XXX-XX-_____

Primary Phone #_____Secondary Phone #_____ Email_____

Address_____City/State/Zip_____

I authorize records FROM:	**To be released TO:**	**To be released TO (2):**
Name_____	Name_____	Name_____
Address_____	Address_____	Address_____
City/State/Zip_____	City/State/Zip_____	City/State/Zip_____
Ph#_____	Ph#_____	Ph#_____
Fax# _____	Fax#_____	Fax#_____
	This is my: ☐ Employer ☐ Insurer	This is my: ☐ Employer ☐ Insurer

For the purpose of: ☐ Disability/FMLA ☐ Self/Personal ☐ Insurance ☐ Workers' Comp ☐ Legal ☐ Narrative ☐ Transfer/Continuity of Care

Dates of Service Range: _____/_____/_____to_____/_____/_____

Records to be released: (please check one or more of the following; see printed records pricing below)

- ☐ X-ray/MRI/CT studies on CD **$8.00**
- ☐ X-rays printed on paper
- ☐ Radiology/X-ray/MRI Reports (no images)
- ☐ Physician Office Notes
- ☐ Physical Therapy Notes
- ☐ Other: (specify) _____
- ☐ Minimum necessary for benefits (Disability, FMLA, etc.) **$10.00 per form**
- ☐ Operative/Procedure Reports
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Attorney Hi Tech Records

Delivery Method: I wish this information be sent via: (CDs can only be mailed or picked up)

- ☐ Mail to address above
- ☐ Secure email to _____
- ☐ Pick up at office: (specify which office location) _____ Person picking up: _____
- ☐ Fax to fax number above
- ☐ Publish to patient portal account **(no charge)**

Fees: I acknowledge there may be fees associated with this request and a prepayment may be required. Charges for medical records follow the current fees allowed by the Ohio Revised code sections 3701.74, 3701.741, 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. **Orthopaedic Institute of Ohio contracts with Verisma to copy and provide all medical records requested from our office. Copy charges plus postage will be invoiced to you from Verisma with all the necessary directions to receive your records. By signing this authorization, you are agreeing to pay Verisma for your records.** In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.

Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Guardian_____ Relationship to Patient_____ Date_____/_____/_____

This authorization will expire one year from the above date unless I specify an expiration date: ____/____/_____

FOR OFFICE USE ONLY:

X-ray/MRI/CT on CD $8.00 $_____

Disability/FMLA Forms $10.00 (ea.) $_____

Narrative $_____

Attorney Hi Tech Records $18.60 $_____

☐ **No Charge** (Continuity of care or patient request)

Third Party; Other than patient or patient's personal representative: **Tax ID:31-1562435**

___A. Initial fee of $23.25 for record search

___B. Data recorded on paper or electronically

_____ $1.53 per page for first 10 pages

_____ $0.79 per page for pages 11-50

_____ $0.31 per page for pages 51+

Imaging printed on paper _____ $2.48 per page

+ Postage $_____ Prepayment amount: $_____

Records copied by:_____ Date_____ Amount Charged: $_____

☐ **Record request sent to Verisma**

PLEASE BRING A VALID PHOTO ID WHEN PICKING UP MEDICAL RECORDS