

Medical Record Release of Information Authorization

Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.

Who

Patient Name: _____ Date of Birth: ____ / ____ / ____ SSN #: (last 4) _____

AKA or Maiden Names: _____

Patient Address: _____

City: _____ State: ____ Zip Code: _____ Phone: _____

Email: _____ Fax: _____

Where

Doctor you would like information from

Doctor or Facility Name: CROSSROADS MEDICAL MISSION
Address: 300 W VALLEY DR _____
City: BRISTOL State: VA Zip Code: 24201
Fax: _____

Where you would like information sent

Please indicate all fields even if you would like the records faxed. Larger files cannot be faxed and RRS will need a complete mailing address

Self

Doctor or Facility Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Fax: _____

What

In order to receive the fastest service, please specify the information being requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows RRS to provide the quickest turnaround times.

Dates of Service: - From: ____ / ____ / ____ To: ____ / ____ / ____

Specific Information: _____

Records will be delivered VIA ELECTRONIC DELIVERY unless otherwise indicated. Deliver on Paper: _____ Yes

Why

Purpose of Disclosure - Please select one:

- | | | |
|---|---|---|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Workman's Comp |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability Determination/Claim | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> 2 nd Opinion | <input type="checkbox"/> Other: |

Legal Requirements

You MUST agree or disagree to each of the following. Please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date ____ / ____ / ____

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated.

Agree _____ Disagree _____ N/A _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Agree _____ Disagree _____ N/A _____ Psychiatric care and/or psychological assessment
Agree _____ Disagree _____ N/A _____ Treatment for alcohol and/or drug abuse.
Agree _____ Disagree _____ N/A _____ Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

Signature

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above-named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent/guardian signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.

Date: _____

Signature of Patient or Authorized Representative