Physician HealthCare Network

MediCopy

8 City Blvd, Ste 400 – Nashville, TN 37209 – 866-587-6274 – www.MediCopy.net

Authorization to Obtain/Release Protected Health Information

MediCopy Services, Inc. is a health information management company that is contracted with Physician HealthCare Network to ensure a more efficient and timely process for fulfilling your medical records requests. MediCopy is fully HIPAA compliant and adheres to all state and federal regulations concerning protected health information.

1: Please Mark One of the Following

☐ I authorize Physician HealthCare Network to ***obtain*** my medical records from:

Dr: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

☐ I wish to have my medical records transferred to another doctor for continuing care.

☐ I wish to have my medical records sent to the address or fax # listed in Section 2*

☐ I wish to have my medical records sent to me:*

☐ Electonically via email: _____@_____

☐ In paper form sent to the address below. (postage fees may apply)

Fee Schedule:
Retrieval Fee: $23.62
Pages 1-20: $1.18/pg
Pages 21-50: $0.59/pg
Pages 51+: $0.24/pg
***I acknowledge that a fee may be charged for this request.**
Initials: _____

2: Mail or Fax Records *TO:*

Name: _____

Address: _____

Address 2: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Email: _____

Patient's Information:

Patient Name: _____

DOB: _____ /_____ / _____

SSN: xxx – xx - _____

Address: _____

City/State/Zip: _____

Phone: _____

Email: _____

(You will be mailed and/or emailed an invoice if applicable.)

3: What would you like released?

Specific Categories

□ All Records □ Office/Clinic Notes □ Operative Reports

□ Lab/Pathology Results □ Radiology Reports □ Immunization Records

□ Dates _____ to _____ □ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure

□ Personal Use □ Litigation/Legal □ Insurance □ Transfer of Care *(Last Two Years sent to a Physician at No Charge)*

Patient's Signature

I hereby authorize Medi-Copy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: