University Medicine

Please complete this form in its entirety

AUTHORIZATION to RELEASE MEDICAL RECORD INFORMATION

Patient Name:	**Date of Birth**:
Address:	
City/State/Zip:	

I hereby authorize my medical record **and all healthcare information** including alcohol and/or drug abuse, HIV testing, behavioral health, genetics testing, sexual and/or domestic abuse and venereal disease to be:

RELEASED TO:	**OBTAINED FROM:**
Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone:	**Phone:**
Fax:	**Fax:**

Information to be Released:	☐ All Records	☐ Treatment dates from _____ to _____ ☐ Other:	
For what purpose?	☐ Transfer out of UMF*	☐ Insurance	☐ Legal
	☐ Continuity of Care	☐ Other	
Medical Record Delivery:	☐ US mail ☐ Fax	☐ Patient will pick up: 17 Virginia Ave. Suite 107 Providence, RI 02905	

* If the medical record is being copied for a provider **who is <u>not</u> a member of UMF (or for any other purpose) there is a small copying fee**. ***<u>Please review and complete the reverse side of this form for fees.</u>***

Medical information is protected under Federal law and Rhode Island General law 5_37.3 and, except as provided by law, cannot be disclosed without written consent. Information released with authorization will not be given, sold, transferred, or in any way relayed to any other person not specified above.

This AUTHORIZATION will expire one (1) year from the date signed and may be withdrawn at any future time and is subject to revocation with written notice to the University Medicine Foundation, Inc.

_____ _____

Signature of Patient or Authorized Representative — Date

_____ _____

Signature of Parent/Legal Guardian (If patient under 18) — Date

***All questions and special requests may be directed to: University Medicine Medical Records, 17 Virginia Avenue, Suite 107, Providence, RI 02905; phone (401) 443-4981. Fax: (401) 383-7090. Email:** HIM@umfmed.org

The information released may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. UM will not condition treatment on payment of the provision of this authorization.

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Patient Record Reproduction Fee Approval Form

Medical records and medical bills may be requested by the patient and/or the patient's personal representative. All medical record requests shall be made in writing through a properly executed Authorization for Release of Medical Record Information form. Reimbursement to the physician for providing a copy of medical records from electronic to paper format will be a flat fee of $15.00 per record based on an average cost per record calculation. The fee for transmitting records in electronic format, if possible, will be a flat fee of $6.50 per record. A special handling fee of an additional $20.00 may be charged if the records must be delivered to the patient or authorized representative within forty-eight (48) hours of the request.

Fees for providing copies to attorneys and/or authorized third parties are in accordance with **RI Code of Regulations R5-37-MD/DO: Rules & Regulations Pertaining to Licensure and Discipline of Physicians 11.2 (d)**

The healthcare provider shall ensure that the copies are transmitted (mailed) within 30 days after receiving a valid written request. An additional 30 days is permitted under federal regulations if an explanation is provided regarding the reason for the delay.

Fee Schedule *(check off all selections that apply)*

It is the goal of University Medicine Foundation to provide our patients various options based on level of need. Based on that principle, please review the following fee schedule:

☐ Paper copies of record: $15.00 flat fee per record.

☐ Electronic Copy: $ 6.50 flat fee per record. ***(Please Note: Not all offices accept electronic records, please check with your provider before requesting this option.)***

☐ Expedited Records: There is a special handling fee of $ 20.00 for records required in **less than 48 hours.** ***In some instances, this turn-around time may not be feasible.***

Please indicate selection(s) above and remit payment with the completed form to:

University Medicine, 17 Virginia Avenue, Suite 107, Providence, RI 02905.
ATTN: Medical Records.

Please be advised that we accept checks, VISA, MasterCard and American Express.

Parent or Guardian if patient is a minor:	
Patient Printed Name:	**Date of Birth:**
Address:	**Phone:**
City/State/Zip:	**Patient Signature:**
Email Address for Electronic Copies:	
☐ **Bill my credit card**	
☐ **Card type/number:** **Exp. Date:**	
☐ **Check Enclosed (Payable to University Medicine Foundation, Inc.)**	