University Medicine

AUTHORIZATION to RELEASE MEDICAL RECORD INFORMATION

Printed 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:**
Physician Name:_____	Physician Name:_____
Address: _____	Address: _____
_____	_____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax:_____

Information to be released: * All Records _____

* Treatment dates from _____ to _____

Information shall be used for what purpose? □ Transfer of Care □ Insurance

□ Legal □ Personal □ Other_____

Medical Record Delivery: _____ via US mail _____ Patient will pick up at:
_____ via Fax 17 Virginia Ave, Suite 107
Providence, RI 02905

A. If the physician is a member of UM the entire medical record will be transferred to the UMF physician of your choice. **There is no fee to transfer the record**.

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

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This AUTHORIZATION will expire one (1) year from the date signed and may be withdrawn at any future time and is subject to revocation with written notice to the University Medicine Foundation, Inc.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 Date
(If patient under 18)

***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**

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

RI Code of Regulations R5-37-MD/DO: Rules & Regulations Pertaining to Licensure and Discipline of Physicians - Medical Records.

11/2 Medical records and medical bills may be requested by the patient or an authorized representative. All medical record requests to physicians shall be made in writing or upon receipt of a properly executed Authorization for Release of Health Care Information. Reimbursement to the physician for copying of medical records shall not exceed 25 cents per page for the first 100 pages. After 100 pages, the fee shall not exceed 10 cents per page. A maximum fee of $15.00 may be charged for retrieval regardless of the amount of time necessary to retrieve the record. A special handling fee of an additional $10.00 may be charged if the records must be delivered to the patient or authorized representative within forty-eight (48) hours of the request. *The healthcare provider shall ensure that the copies are transmitted (mailed) within 30 days after receiving a valid written request.*

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:

_____Provide a 2 year abstract (includes 5 years of diagnostics). Copy fee is $20.00.

_____ Entire record. You will be invoiced at the allowable RI Statute Copy Fee: $15.00 clerical fee, plus $.25 for the first 100 pages, $.10 for any pages over 100, plus postage.

_____Any records requiring mailing will have a cost of shipping and handling of $3.50 added to the order.

_____There is a special handling fee of $10.00 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.

_____
Patient Signature

_____ Date of Birth: _____
Print Name

_____ _____
Address Phone

____ Bill my credit card. Card type/number: _____ Exp Date:_____

____ Check Enclosed (Payable to University Medicine Foundation, Inc.)