



Medical Records Release

Please Print Clearly & Fill-in All Sections Completely

Patient's Name: _____ Date of Birth: _____ Last Four of SSN: _____

Address (street, city, state & zip code): _____

I authorize Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio, custodian of my medical records, to disclose/release the following Protected Health Information: (please check all that apply)

All Records Operative Reports Progress Notes X-ray/Radiology Records

Billing Records Other _____

OR: Release ONLY the specific dates of service as listed: _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing the disclosure of this information.

Please send the records indicated above to:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

The information being requested is for (please mark all that apply):

- Second Opinion
- Specialist Care
- Permanent Transfer of Care
- Legal (Specify) _____
- Temporary Transfer of Care (Indicate Dates) _____
- Other (Specify) _____

This authorization is valid for one-hundred-eighty (180) days from the date it is signed. I understand that after the custodian of records for Orthopedic Associates of SW Ohio and/or the Hand Center of Southwestern Ohio discloses my health information, it may no longer be protected by federal privacy laws. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. I may revoke this authorization in writing, at anytime. I understand that a revocation of this authorization has no effect on records that have already been disclosed in response to authorizations received prior to the written notice of revocation. Written revocation is effective upon receipt by the Medical Records Department of Orthopedic Associates of SW Ohio. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or patient's representative)

Date

Printed name of patient or patient's representative

Representative's authority to sign for patient
(i.e. parent, guardian, power of attorney for healthcare)

All records will be mailed by ScanSTAT to address listed above. Please allow 30 days for completion.

Signature OASWO Witness: _____ Date: _____

Printed name of OASWO Witness: _____



Orthopedic
Associates
of SW Ohio



Tips for Receiving Medical Records Promptly

1. Please fill out the attached form completely, leaving no blanks. Please make sure your complete address is noted on the request to include the street, city, state, and zip code.
2. Please print clearly
3. The “Send Records To:” area must be filled out with a complete mailing address, telephone, and fax numbers.
4. Requests for/by attorneys, insurance companies, disability claims, and SSI are charged to the requestor.
5. Requests are processed by ScanSTAT. Please allow 30 days for completion of records requests.
 - a. ScanSTAT Medical Records (770)569-2445
6. If the “All” records box is checked, then all records will be sent to the requestor. If the release indicates a specific time period or specific dates where noted in bold print on the authorization, i.e. **OR: Release ONLY the specific dates of service**, then **ONLY** those records can be sent to the requestor. This is due to HIPAA rules/regulations. If both the “All” records and specific time period boxes are checked, then only the records from the specific time period will be forwarded to the requestor.
7. If the requestor requires billing information, the “billing” box must be checked for the information to be released.