THE WASHINGTON ENDOCRINE CLINIC PLLC

# MEDICALRECORDS RELEASE FORM

**This form has been approved by the Dept. of Health and Human Services.**
**This is the only form the Clinic will accept for a transfer of medical records.**

Patient's Name: _____ Date of Birth: _____

Patient's current address: _____

Person(s) or medical provider(s) to whom protected health information (PHI) should be released:

Name: _____

Address: _____

**How do you want the records released?**

- ❑ Fax to the following number: _____.
- ❑ Hard Copy – mailed to the address you provide above.
- ❑ E-mail – HIPAA laws (according to the "Final Rule" update to HIPAA laws) now allow for medical records to be e-mailed. However, by checking this box you signify that you understand and accept that the e-mail sent will be unencrypted and you will assume any and all risk associated with sending unencrypted e-mails. E-mail address to use: _____.

**Cost for this release request (This form will not be processed if this box is not checked.)**

❑ I understand that HIPAA laws allow for the Clinic to charge a patient a reasonable fee for the right to access protected health information. These fee include for such items as the cost of copying, supplies, labor, and postage. Unlike the other 50 states in the US, the District of Columbia does not regulate these costs. The Clinic sets these costs based upon an examination of other state laws. The current charge is $1.50 per page for the first 10 pages, and then $0.75 for pages 11-500. These cost limits apply to both electronic and paper copies.

**Time frame to process request (This form will not be processed if this box is not checked.)**

❑ I understand that HIPAA laws allow a processing time of up to 30 days to process a request for medical records. However, the Clinic tries to complete this process within 3-5 business days after receipt of this form.

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**Specific records to be released:**
HIPAA laws allow the Clinic to include in a "medical record request" records that the providers at the Clinic used to make decisions about patients. These can include such additional items as medical records brought/sent to the Clinic by a patient from other healthcare providers, billing records, and/or registration papers. Many patients have found that they do not need all of these records as they have kept a copy of records provided to the Clinic from other healthcare providers, and have received insurance billing records directly from their specific insurance company. (Patients who want insurance EOBs should contact their specific insurance company for a copy of these EOBs).

**Please note:** You **cannot** request a particular document. The Clinic staff processing this form does not have medical training to identify particular documents. If you check the first box, this will include ALL records in your medical file.

- ❑ I only want released the medical notes from each visit, labs, radiology, and/or pathology reports that were ordered by providers at the Clinic.
- ❑ (for patients with diabetes) Also include all diabetic insulin pump downloaded reports, glucometer download reports, and personal glucose logs.
- ❑ Also include all medical records in my file from healthcare providers outside the Clinic
- ❑ Also include all billing records (does not include insurance EOBs).

**HIV/AIDS:** I DO ❑ DO NOT ❑ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ Date: _____

By signing this form, I authorize the Washington Endocrine Clinic to release protected health information (PHI) to the person(s) or entity listed above.

Patient Signature: _____ Date _____
***(For patient protection under the HIPAA laws, an actual signature from the patient is required – please do not just type your name.)***

**Method of Payment:**
The Clinic accepts payment for this medical record request in the form of a credit card, debit card or cash. Checks are not accepted. If you are paying by credit card, you must provide the following for this form to be processed:

Credit Card # _____ Exp date _____

Street number or house number of credit card billing statement: _____.
For example, if you live at 9925 Main St, City, State, USA 12345, please write in the space above "9925".

Zip code of the credit card billing statement: _____
For example, if you live at 9925 Main St, Anywhere, USA 12345, please write in the space above "12345".

**Send back to us:**
#1 – Fastest way: Fax 202-446-2946
#2 – Mail to: Washington Endocrine Clinic, 1712 I St NW, Ste 1006, Washington DC 20006