Copper Ridge SURGERY CENTER

Patient Medical Record Request Form

1. Patient Information:

Name			Birthdate:
Street Address			
City	State	Zip Code	Phone #
Fax:	Email*:		

2. Access Requested (Guidelines available on reverse**):**

☐ **Patient requests Copy of Medical Record** ☐ **Patient requests Inspection of Record on Site**

☐ **Patient requests a Copy of Medical Record be delivered to a Third party (i.e. Family, Physician Office)**

For one-time Third-Party Requests, please provide contact information.

Name – (e.g. Insurance Co., Lawyer, Family Member)			
Street Address			
City	State	Zip Code	Phone #
Fax:	Email*:		

3. Description of information to be disclosed (fees may apply, see reverse side):

☐ **Complete copy of records**

☐ **Other (identify portions of the record to be disclosed)**:

☐ Lab results, pathology reports ☐ Operative Note ☐ Anesthesia Record ☐ Financial History Report

☐ X-Rays ☐ Record of HIV and communicable disease testing ☐ Other:_____

4. Please indicate preferred delivery method (paper, mail, email, fax, other):_____

***Note that some email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our facility. Do not include a recipient email address if this is of concern to you.

In accordance with the conditions provided on this form, I authorize the use and/or disclosure of my medical information. I understand there may be a charge for copies.

Signature: _____ **Date:** _____

(Patient or Legally Authorized Representative)

****PLEASE SEE REVERSE SIDE FOR FURTHER INFORMATION****

STAFF USE ONLY:

☐ **Information Released as Above**. Staff Signature/Date: _____

☐ **Legally Authorized Representative verified if signed by individual other than patient.**

Type(Parent/Guardian/Third Party):_____

Staff Signature/Date**:** _____

4100 Park Forest Drive
Traverse City, MI 49684

Phone: 231-392-8900
Fax: 231-392-8973

Copper Ridge SURGERY CENTER

Additional information regarding disclosure of patient medical information

Copper Ridge Surgery Center honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Federal HIPAA Privacy Rules. These federal rules indicate when your protected health information may be used or disclosed without your authorization. Please see our Notice of Privacy Practices for additional information.

No obligation to sign. You are under no obligation to sign this form and you may refuse to do so. Except as permitted under applicable law, Copper Ridge Surgery Center may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if the authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: Copper Ridge Surgery Center, Attention: Medical Records, 4100 Park Forest Drive, Traverse City, MI 49684.

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they may receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect a copy of your medical information, with certain exceptions provided under state and federal law. Access to inspect PHI is provided on a scheduled basis. Original documents may not be removed from the facility. If you would like to inspect your records, contact the Medical Records department of the Copper Ridge Surgery Center at 231-392-8900.

Copying Fees. If you are requesting disclosure/release of medical information to other hospitals, clinics or physicians for further medical care, no copying fees will be charged. You must pay for copies you request for other purposes.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of medical information. If you are under the age of 18, your parent or a guardian must sign this form for you.