Request Copy of Patient Medical Information/Records

Medical Records Policy

Harmonious Living Chiropractic: Fitness & Wellness Center is dedicated to protecting our patient's personal health information (PHI). Patient medical records are strictly confidential and access to such records must be authorized and approved by the patient (except when the patient is a minor). Patients or their representatives with legal medical power of attorney may authorize release of the patient's PHI.

Custodian of Patient Medical Records: Patients' medical records are the property of Harmonious Living Chiropractic: Fitness & Wellness Center is the custodian of the patient medical records. Patients have a right to request a copy of their medical records. A request for patient medical records must be done in writing. An oral request for medical records will not be honored or fulfilled.

Medical Records Request by Patient: Patients can request a copy of their medical records by completing and returning the *Request Copy of Patient Medical Information/Records* (pages 2-3)form to our office. Request for medical records from a patient will be subject to fees as allowed and permitted by the State of Maryland.

Medical Records Request by Third-Party: Medical records for patients will not be released without a written authorization from the patient or parent/legal guardian (if patient is a minor). Third-party includes insurance companies, attorneys, parents of patients, etc. Request for medical records from a third-party will be subject to fees as allowed and permitted by the State of Maryland. To request a copy of a patients' medical records, complete and return the *Request Copy of Patient Medical Information/Records* form (pages 2-3), in addition to signed authorization of release, to this office.

Completion of Request: Medical records request may take up to 30 days to complete. Once the request has been completed, we will contact you by phone and/or email. Do not contact the office unless you have not received a phone call and/or email after 30 days of submitting your request.

Paying for Medical Records: The payment for medical records is the responsibility of the requesting party. You will receive an invoice after your request has been fulfilled. Payment is required before medical records are released to the requesting party. This service cannot be billed and/or paid by your insurance.

Medical Records Service Fees:

- Administrative Fee (supplies and labor): $22.88
- Per page fee: $0.83
- Certified mailing fee (according to United States Postal Service fee schedule)

Receiving Medical Records: Medical records will be released to the requesting party in-person or sent via certified mail to the address provided on the request form. Medical records can be faxed or mailed; and will not be sent via email.

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202
Phone: 240-264-6372 | Fax: 1-888-375-5167
www.drtiffanybutler.com

Request Copy of Patient Medical Information/Records Form

To request a copy of patient medical records, complete the following steps:

1. Fill out the form in its entirety.
2. Return the completed form (and photo ID, if necessary)* to our office by:
    a. Fax: 1.888.375.5167
    b. Mail: Harmonious Living Chiropractic, PO Box 558, Columbia, MD 21045

**If you are a parent and/or legal guardian requesting a copy of your child's medical records, be sure to send a copy of your photo ID with this form.*

**If you are a third-party (e.g., healthcare provider office, attorney office, et.) requesting this a copy of a patient's medical record, be sure to send a copy of the authorization of release of medical records (or similar document) bearing the patient's signature with this form.*

3. Once we receive your request, an email will be sent to the email address provided with further instructions.

Do not return this form by email. It will not be honored. If you have any questions or concerns, call us at (240) 264 – 63872 during normal business hours.

Section A: Patient Information

Patient First and Last Name: _____ Date of Birth: _____

Home Address: _____

Email Address: _____ Phone Number: _____

Section B: Requester Information

Name: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

Check one of the following:

□I am the patient requesting a copy of my medical records.
□I am the parent or legal guardian of the patient, requesting a copy of my child's medical records.
□I am an attorney or law office requesting a copy of the patients' medical records
□I am an insurance company requesting a copy of the patient's medical records.
□I am a healthcare provider, facility, hospital, etc. requesting a copy of the patient's medical record.

Reasons for Request (check all that apply)

□Billing □Insurance Dispute/Appeal □Continuation of Care □General Review □Other.

Which Medical Records Are You Requesting? (Check all that apply)

□Treatment Notes (including history, examination, progress notes, etc.) □Billing Records

What Dates of Services Are You Requesting (Do not leave blank).

For the date(s) of service from **_____ to _____**.

Requester Signature: _____ Date: _____

Section C: Receipt of Medical Records (Check one)

It is our office policy that we provide medical records by the following methods:

1) **Pick-Up:** Requesting party can pick-up medical records at our office during a pre-determined time.
2) **Certified Mail:** Medical Records will be mailed using certified mail to the designated mailing address provided on this form.
3) **Fax:** Medical Records will be faxed to the designated fax number provided on this form.

Please Note: Patients do not have access to their medical records via a web portal or other electronic means; therefore, we do not send patient's medical records via email.

Important Notice: If medical records are delivered to the requesting party other than by pick-up at the office, such as via mail and/or fax, it is the designating party's responsibility to take extra precautions to protect the patient's personal health information. While mailing and/or faxing are not the most secure method of delivery, it does pose a risk of personal health information being intercepted, misaddressed, misdirected, undelivered and/or lost during the mailing and/or faxing process. For this reason, we encourage picking up medical records from our office to avoid such mistakes. By choosing to receive the patient's medical records by mail or fax, the requester acknowledges and accepts these risks. Requester of patient's medical records understand there may be a fee for a copy of Medical Records. The requester further understands that all fees will be in compliance with the applicable law. Prior to receiving such medical records, the requester agrees to pay the appropriate fees.

DO NOT WRITE BELOW THIS LINE – INTERNAL USE ONLY

Date Received:		
Date Requester Contacted:		
Date Payment Received:		Amount: $
Date Processed:		
Date Sent/Given to Requester:		□Fax □Mail □Pick-Up
Date Affirmed Notice Received:		□Email □Phone □Letter

Additional Notes/Comments: