Request Doctor to Review Medical Records/Case (e.g. 2nd Opinion)

Medical Records/Case and 2nd Opinion Policy

This policy demonstrates Harmonious Living Chiropractic: Fitness & Wellness Center's commitment to providing the community access to review medical records/case and/or second opinion form a qualified health professional.

Non-Patient: Currently, our chiropractor only offers impairment evaluation and independent medical evaluations (IMEs) to non-patients (termed "examinee").

Non-Medical Treatment/Services: Review medical records/case and/or second opinion can be initiated by a current patient or third-party. Healthcare providers and physicians who desire to obtain a second opinion on their patient should contact the office or provide the patient with a referral for a chiropractic consultation.

Paying for Services: A review of medical records/case and/or second opinion will be provided to current patients being treated for current complaint(s) at no additional costs. If a current patient is requesting review medical records/case and/or second opinion on complaint(s) that are unrelated to what is being treated for in the office, there may be responsible for such services. If the medical records/case and/or second opinion is requested for a non-patient, the requesting party will be responsible for paying for such services.

Fees for Review Medical Records/Case (e.g. 2nd Opinion): If we decide to initiate these service(s), we will discuss fees for such services after during the initial consultation.

Requesting for Services: To request a review of medical records/case and/or second opinion, please complete and return the *Request Doctor to Review Medical Records/Case (e.g. 2nd Opinion)* application to our office in-person, fax, or mail.

Complete and return *Request Doctor to Review Medical Records/Case* form to our office:

Fax to: 1.888.375.5167

Drop-Off at: the office during our normal operating hours.

Mail to: PO Box 558, Columbia, Maryland 21045

If you have any questions regarding the policy or the application, please call the office at (240) 264 – 6372 or email info@drtiffanybutler.com

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 Doctor to Review Medical Records/Case (e.g. 2nd Opinion) Form - Application

To request an review medical records/case (e.g. 2nd Opinion), 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 21202

**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: Examinee Information

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

Home Address: _____

Email Address: _____ Phone Number: _____

Section B: Requester Information – Complete if different from Examinee

Name: _____

Email Address: _____ Phone Number: _____

Relationship to Examinee: (check one)

□Self/Examinee/Patient

□Parent/Legal Guardian of Examinee

□Attorney/Law Office Representing Examinee

□Insurance Company

□Other: _____

Services you are requesting: (check all that apply)

□Medical Records/Case Review
□Second Opinion

Injury Information

Exact Date of Injury: _____

Type of Case: □Auto Accident □Workers' Compensation □Other: _____

Did/Do you have an attorney representing you? □Yes □No

Did you receive care for your injury? □Yes □No

If "yes" where did you receive care? (Check all that apply):

□Chiropractor □Physical Therapist □Occupational Therapist □Primary Care Physician

□Neurologist □Orthopedist □Other: _____

Requester Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE – INTERNAL USE ONLY

Date Received:		
Date Requester Contacted:		
Date Payment Received:		Amount: $
Date Processed:		
Date Appointment Made:		
Date Appointment Records Completed:		
Date Notice of Completion Sent to Requester		□Email □Fax □Phone
Date Report Sent to Requester:		□Fax □Mail
Date Affirmed Notice Received:		□Email □Mail □Phone □Fax

Additional Notes/Comments:

Make copy of all completed form(s) and placed into examinee's file. Give the examinee or requesting party the original copy.

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