Medical Records Release Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Children's Medical Services may verify your identity/ guardianship. Some requests may be subject to a reasonable fee.

Patient Information

Patient Name: ________________________ Date of Birth: ______________

Street Address: ____

City: ________________________ State: ________ Zip Code: ____________

Phone Number: ____________________

Release Information

What information are you requesting? *(Mark all that apply)*

Date(s) of service: ________________________________

☐ History/Physical Exam Notes

☐ Orders/supply requests

☐ Billing (Claim) Information

☐ Other: ____

Third Party Disclosures

Person(s) or Medical Provider(s) to whom protected health information (PHI) should be released if other than self. ***If requesting for personal use, indicate NA.***

Name: ________________________ Phone Number: ______________

Street Address: ____

City: ________________________ State: ________ Zip Code: ____________

I want the requested medical records to be sent to the third-party (for example, an employer or a school). My completion of this form serves as authorization for Children's Medical Services to disclose these records to this person or group. I understand that once my information leaves Children's Medical Services, Children's Medical Services is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

How do you want these records released?

☐ Fax to the following number: ______________________________

☐ Encrypted E-mail to address: ____

☐ Hard copy sent via USPS to the following address:

Street Address: ____

City: ____ State: _________ Zip Code: ______________

☐ Other: ____

Terms of Authorization

I understand this authorization may be revoked in writing at any time, according to the instructions Children's Medical Services of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here: __________________. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that HIPAA laws allow for Children's Medical Services to charge a patient a reasonable fee for the right to access protected health information. These fees include for such items as the cost of copying, supplies, labor, and postage. The current charge is $1.50 per page for the first 10 pages, and then $0.75 for pages 11-500. These cost limits may apply to both electronic and paper copies.

I understand that HIPAA laws allow a processing time of up to 30 days to process a request for medical records. However, Children's Medical Services tries to complete this process within 7-10 business days after receipt of this form.

Signature: ____ Date: ___________________________

Printed Name: ____

Relationship to Patient: ____

Please print, complete and mail or deliver completed forms to:

Children's Medical Services
630 N. Prince Lane
Springfield, MO 65802

Fax: (417)882-9441

Or

CHILDMED@KIDSMEDSUPPLY.COM