REQUEST FOR MEDICAL RECORDS

Complete the Authorization for Release of Medical Information form in its entirety.

Mail the completed form to: Or fax to: 803.933.6346

Midlands Orthopaedics & Neurosurgery
Medical Records
1910 Blanding Street
Columbia, SC 29201

The form may also be dropped off at any of our locations. Allow up to ten business days for the request to be processed.

In accordance with South Carolina Statute 44-115-80 and HIPAA Rule 45 CFR § 164.524 (c), you will be billed for the reproduction of your medical records as outlined below:

PHYSICIAN / CONTINUING CARE: No Charge
Records will be delivered directly to the provider. Please complete all fields to avoid any delay in delivery.

PERSONAL COPY:
$6.50 fee for individual access request based on average labor for reproduction
Records will be delivered to the address indicated on your request.
Please complete all fields to avoid any delay in delivery.
Please provide a legible email address for electronic delivery.
FOR PAPER COPY MAILED REQUESTS ONLY
$0.01 per page mailing cost for paper and toner
$0.15 per envelope mailing cost
Actual Postage

Please submit questions concerning your request securely by logging into the Patient Portal via our website, *www.midorthoneuro.com*. Click on the Patient Portal link. Log-in. Click "Send a message" to submit a question.

Release of Information Partner
We have partnered with **RecordQuest** to provide the safest and fastest delivery of your medical records. You will receive an invoice by email, fax, or US mail indicating the charges. Please follow instructions indicated on the invoice from RecordQuest for payment and delivery options.

Payment address: RecordQuest, PO Box 2017, Mt Pleasant, SC 29465-2017
If you have a question about your Records statement, you should contact RecordQuest directly.
(Phone) 888-300-7410 Email inquiries to roi@recordquest.com

MIDLANDS ORTHOPAEDICS & NEUROSURGERY, P. A. (MON)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient's Full Name | Birth Date (Mo/Day/Year)

Street Address | Social Security Number

City, State, Zip Code | Phone (Home)

At the request of the individual, I _________________________, do hereby authorize MON to release:
(Patient's Name)

DATES OF SERVICE:

__ DISCHARGE SUMMARY
__ ECG/EEG/CARDIAC CATH
__ EMERGENCY REPORTS
__ HISTORY & PHYSICAL
__ IMAGING
__ LABORATORY REPORTS
__ OPERATIVE NOTES
__ PATHOLOGY REPORTS
__ PROGRESS NOTES
__ RADIOLOGY REPORTS
__ OTHER______________

___ I DO ___ I DO NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE RECORDS TO:______________________________
Name of Company/Agency/Facility/Person

Street Address | Phone:
Fax:
City, State, Zip Code | Email Address:

PURPOSE OF DISCLOSURE:

__ REFERRAL TO SPECIALIST
__ DISABILITY DETERMINATION
__ INSURANCE
__ PERSONAL
__ WORKERS COMP
__ CONTINUING CARE
__ CHANGE OF DOCTOR
__LEGAL INVESTIGATION

OTHER (SPECIFY): ____

Please provide a current telephone number in the event we need to contact you: _______________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

____ | _________________
Signature of Individual/Guardian/Personal Representative of patient's estate | Date