WESTSHORE PRIMARY CARE

Dear Patient:

Diversified Medical Records Services, an outside company specializing in managing correspondence copying for medical facilities, now processes all requests for copies of medical records for our office. Diversified Medical Records Services was founded in 1992, is fully HIPAA compliant and adheres to all state and federal regulations concerning health information.

Copies of your medical records are available to you for a small pre-payment fee, which covers such costs as labor, paper, supplies, equipment maintenance costs, and postage. The fees for various options are listed below.

**Options:**

- **Option 1**: **2 year summary** of pertinent health information: $15.00.

- **Option 2**: **Entire Chart:** $15.00 plus additional fee per page. Please note ENTIRE CHART on your request. Total cost varies and is calculated using state regulated rates. You will receive an invoice for the remaining fee. Records are not released until that invoice is paid in full.

- **Option 3**: **Digital Keychain:** $49.95 for a five year history of health information provided to you on an encrypted USB flash drive that can be carried on your keychain or in your wallet. Please make a check next to the style of Flash Drive you would prefer.

_____USB Keychain Flash Drive  _____USB Credit Card Flash Drive 

- **Option 4: Personal Health Record on Mx247.net:** approx. $5/month. Diversified will provide a private and secure area for your Personal Health Record, as well as your actual records from your physicians. With Mx247 your records are secure, up-to-date and on-line at any time, from any internet-connected computer 24 hours a day, seven days a week. Simply go to Mx247's website: www.Mx247.net for more information. You will also receive a **FREE** Digital Keychain of your choice (Option 3 above) when you sign up for Mx247! We do all the paperwork, submit all the forms, and even update your records for you based on your preferences.

Please mail your signed form and payment to:

**Westshore Primary care**
**Attn: DMRS**
**29325 Health Campus Drive, Suite 2**
**Westlake, OH 44145**

~ Request will not be processed without pre-payment ~

**If you need further information, please call Diversified Medical Records Customer Service at (800) 359-8520.**

***If you choose to sign up for Mx247, you need not return this form. Use Facility ID OHC0122***

SHEFFIELD VILLAGE OFFICE
5323 Meadow Lane Court • Suite A & B • Sheffield Village, Ohio 44035 • Phone: (440) 934-0276 • Fax: (440) 934-0272

Diversified Services
medical records

# Authorization for Release of Protected Health Information

This authorization complies with the HIPAA Privacy Rule

**Patient Information:**

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____ Last 4 Digits of SSN#: _____

Personal Email Address: _____

*(Please write clearly and double check for accuracy. Failing email addresses will default to U.S. Mail)*

**Recipient Information:**

Please choose the method of delivery by checking the box that applies and filling in the information required. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ Please email me the records.
*(Records will be sent to the email address listed above)*
*(Email recommended for fastest delivery of records)*

☐ I prefer to pick my records up personally. Please call me when they are ready.
*(Photo ID will be required for pick up)*

☐ U.S. Mail: To my personal address.
*(Records will be mailed to address listed above)*

☐ U.S. Mail: Attn: _____

_____
Street Address

_____
City State Zip Code

_____ _____
Phone # Fax #

**Notice of Cost:**

Please note that there may be a cost involved in obtaining copies of your records. Refer to the attached policy letter for the breakdown of fees and where they apply. Payment must be included with request.

**(Optional) Electronic Health Information:**

We can provide a second copy of the health information you are requesting on CD/DVD or USB Micro drive for an additional fee. Please check the box that applies to your preference, and include a check for the appropriate amount. (Products will not be delivered without prepayment included.)

**Please Note: This is an additional service option.**

☐ Records on CD/DVD ($20.00) ☐ Records on an Encrypted Micro USB drive ($49.95)

*(Please allow 7-10 days for delivery. Products are shipped via UPS. Shipping details will be emailed if address is provided above.)*

**Information to be Released:**

Below, please detail the amount or specific type of health information to be released.

☐ Abstract (pertinent health summary) ☐ Entire Chart ☐ Specific Records (see below)

Only check the boxes below if you are requesting specific records to be released. (*Check all that apply*)

☐ Progress Notes ☐ Labs ☐ X-Rays ☐ Other _____

For the following dates of treatment: _____

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*(For example: specific date 6/29/07 or a range of dates July 2005 to Present)*

**Purpose for Disclosure:**

The reason I am requesting this information to be released is: _____

**Protected Health Information:**

If your record contains any of the following sensitive information, you must specify that you **DO** want it released. Check the boxes below and initial the line next to the information you want released.

☐ HIV/AIDS ____ ☐ Mental Illness ____ ☐ Drug/Alcohol Abuse ____ ☐ Genetic Testing ____

**Legal Notices:**

- ✓ I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- ✓ I am entitled to a copy of this authorization upon my request.
- ✓ I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
- ✓ The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
- ✓ Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law.
- ✓ I understand that this authorization will expire in 90 days from the date of my signature.

**Signature of Release:**

I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative Date

_____ _____
Signature of Witness (Mental Health releases must be witnessed) Date

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