Patient Health Information Release Authorization

I ______________________________ *hereby authorize* ____

PATIENTS FULL NAME — MEDICAL FACILITY or PHYSICIAN NAME

to disclose my health information under the terms described below. Pursuant to this authorization, my health information may be disclosed to, and used by, the following individual or organization.

PLEASE **CAREFULLY** CHECK **ONE**

☐ **My Self** (*Records will be mailed to your home address*) ☐ **OTHER** (*Please detail below*)

NAME AND ADDRESS OF **OTHER** INDIVIDUAL OR ORGANIZATION YOU ARE AUTHORIZING YOUR HEALTH INFORMATION BE DISCLOSED TO:		
Name:		
Address:		Apt/Ste #:
City:	State:	Zip:

Specific information to be used and/or disclosed: (CHECK and FILL IN ALL THAT APPLY)

☐ **All** records regarding treatment for the following condition or injury (specify):			
OR	Dated From		Dated To
☐ Specific 'Progress Notes':			
☐ Test Reports of:			
☐ X-Ray **Films** of:			
☐ X-Ray **Reports** of:			
☐ MRI **Films** of:			
☐ MRI **Reports** of:			
☐ Other (Specify):			

The purpose of this disclosure is:	☐ Medical Care	☐ Legal Matter	☐ Insurance	☐ Personal

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING AT THE BOTTOM

I understand that if my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome **(AIDS)** or human immunodeficiency virus **(HIV)** related information, such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that an HIV test was done; HIV virus is present; HIV related illness or AIDS; or any information which could indicate that a person has been potentially exposed to HIV. I also understand that if my records contain information concerning **Drug**, **Alcohol** abuse and/or treatment, or behavioral, mental health services or **Psychiatric** treatment, domestic/sexual abuse, such information will be released pursuant to this authorization. **Unless otherwise revoked, this authorization will expire in 90 days.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical facility or Nova Records Management at (732) 698-9950.

Exceptions to the above, I do not authorize the release of the following:			
☐ Mental Health	☐ Substance Abuse/Alcohol Abuse	☐ HIV/AIDS	☐ Domestic/Sexual Abuse

DOB: / /		Phone: ( ) -	
SS:(Last 4 Digits Only) ________ _________ _______ ________		Fax: ( ) -	
Address:			City:
State:	Zip:	Email:	
X Patient Signature: Date:		X Parent/Guardian Date:	

THIS AUTHORIZATION WILL BE CONSIDERED INVALID WITHOUT AN APPROPRIATE SIGNATURE AND THE PATIENTS DOB AND SS#!

MEDICAL INFORMATION REQUEST FORM

FREQUENTLY ASKED QUESTION (FAQS) AND INSTRUCTIONS

◊ How do I obtain a copy of my medical record?

- You can request copies of your health information by printing and properly completing the attached 'Patient Health Information Release Authorization' form and submitting it to Orthopedic Associates of Dutchess County by either mail or secured fax.
- Your completed authorization must include your signature, date of birth and social security number.

◊ How much does it cost to obtain a copy of my medical record?

- New York State Public Health Law provides for a fee of .75¢ per page for copies of medical records.*
- As per NY State Law, applicable sales tax will be added.
- The cost of postage to mail your records will also be applied.
- X-Ray and other radiological film duplications are additional and require pre-payment. An NOVA representative will contact you to provide a cost estimate prior to any radiological film duplication.

To reduce your cost, you should consider requesting specific information rather than a complete record. You can do this by specifying the date(s) of treatment or the time frame for which you are requesting your records.

**Pursuant to NY State PHL law, sec 18, patients who can prove their inability to pay the stated fee may receive paper copies at no charge.*

◊ How will I be billed?

- **Paper records:** An invoice detailing the copy fees will be sent to your home address upon the release of your records.
- **Radiological Films:** We require prepayment before processing X-ray's, MRI's, etc. An NOVA representative will review your request for radiological film copies and contact you to make the appropriate arrangements. All radiological film duplications are sent via United Parcel Service. To save time you can download a credit card authorization form from our website and submit it with your authorization. Our web site is www.roi.novarecordsmgmt.com.

◊ What are my payment options?

- Check, MasterCard, Visa and Debit card (Debit card must be linked to a major credit card listed here).

◊ How long will it take to get a copy of my medical record?

- The turnaround time to obtain copies of your medical records is generally five (5) business days, depending on the availability of the medical record. Saturdays, Sundays and holidays are not recognized business days.
- Requests are prioritized by the necessity of need. Priority is given to requests for the continuation of care.
- Requests that include radiological image duplications generally require additional time for processing.

◊ Can I pick up the copies at my providers office?

- No, all requested copies are either mailed to the patient's home or another address specified by the patient on the Release Authorization form. Special consideration will only be given only for extreme circumstances.

NOVA Records Management

More FAQS

◊ Who is Nova Records Management? (NOVA)

- NOVA provides Release of Information services for medical facilities throughout the Northeast. Our services are tailored to meet the needs of demanding and busy practices that are inundated with requests for copies of medical information. NOVA helps them to ensure their release process is, and remains, safe, efficient and compliant, so they can get back to what's most important.... your healthcare.
- NOVA and the medical facilities we serve, strictly adhere to all state and federal guidelines regarding the retention, release and use of confidential medical information. Patient information will not be released, either verbally or in writing, without a properly completed authorization form signed by the patient, or in the case of a minor, a parent or legal guardian.

◊ Can I request to take home my original medical records?

- New York State Law requires physicians to retain patients' original records for six years [Section 6530(32)]. However, patients have the right to review and obtain copies of their own health information under the provisions of the New York State Public Health Law (chapter 497, section 18 regarding access to patient information).

◊ Can my spouse or other party request my medical information?

- Only a patient can request and authorize the release of their own records.
- Exceptions:
  - A custodial parent may sign for a minor child under 18 years of age
  - A health care agent or proxy
  - A court appointed guardian, upon presentation of documentation
  - An emancipated minor (as defined by New York State law)
- Authorizations are not required for:
  - Disclosures to other physicians for medical emergencies or continued care
  - Disclosures authorized by a court order
  - Disclosures to report to State and Federal databases

◊ Can I have my medical records released to another individual?

- Yes, provided you specify the recipients name and address in the appropriate section of the 'Patient Health Information Release Authorization'.

◊ How long does my provider retain my original medical records?

- New York State Law requires physicians to retain the patients' original records for six years from the date of the patients' last visit. [Section 6530(32)]. Most medical facilities destroy records after this retention period.

◊ Can NOVA fax or email my medical records?

- NOVA will only fax or email medical records upon the receipt of the patient's written approval that specifies the fax number or email address, as well as the intended recipients name.

◊ Who do I contact if I have additional questions?

- If you have questions regarding your request, our representatives will be happy to assist you Mon thru Fri, 8am - 5pm. Call (732) 698-9950.