PIONEER PHYSICIANS NETWORK

MEDICAL RECORD RELEASE AUTHORIZATION

Please fax to: (330) 634-1329

PATIENT INFORMATION:

Patient's Last Name, First Name, MI | Previous Name | Date of Birth (Month/Day/Year)

Street Address, Apt # / Suite (Include Complete Mailing Address) | Social Security Number | Home Phone Number/Alternate Number

City State Zip | Email Address

I HEREBY AUTHORIZE RECORDS AND PLAN OF CARE FROM:

❑ **Pioneer Physicians Network**

"or" ❑ **Other** - _____

Organization/Person/Entity/Name

Street Address, Apt # / Suite (Include Complete Mailing Address)

City/State/Zip | Phone Number | Fax Number

TO BE RELEASED TO:

❑ **Pioneer Physicians Network – Att:** _____

"or" ❑ **Other** - _____

Organization/Person/Entity/Name

Street Address, Apt # / Suite (Include Complete Mailing Address)

City/State/Zip | Phone Number | Fax Number

TREATMENT DATE(S) TO BE DISCLOSED: From _____**to**_____**.**

DESCRIPTION OF INFORMATION TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) ABOVE:

❑ Abstract/Summary of Medical Records for personal or physician use ❑ Complete Medical Records

"OR" SPECIFIC DOCUMENT(S) TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) ABOVE:

❑ Physician Office Note(s) ❑ Laboratory Report(s) ❑ Diagnostic Test/Report(s) ❑ Itemized Bill(s) ❑ Immunizations

❑ Radiology/X-ray/MRI Report(s) ❑ Pathology Report(s) ❑ Operative Report(s) ❑ Other, specify _____

This information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

SPECIFIC INFORMATION NOT TO BE DISCLOSED:_____

PURPOSE OF DISCLSOURE: (Check all that apply).

❑ Self/Personal Use
❑ Disability
❑ Legal/Litigation
❑ Workers Comp
❑ Insurance
❑ Continuation of Care
❑ Transfer
❑ Other, explain - _____

- I authorize that this information to be mailed, faxed, and/or sent electronic delivery when applicable.
- I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to **re-disclosure** and will no longer be protected by Privacy Protection Rules. I understand that I have the **right to revoke** this authorization at any time and that my revocation must be submitted to Medical Records Department at Pioneer Physicians Network. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. 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. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits.
- I hereby authorize Pioneer Physicians Network and/or MediCopy Services, Inc. to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release Pioneer Physicians Network and/or MediCopy Services, Inc. from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released via mail, fax, and/or electronic delivery.
- **Fee Information***:* Pioneer Physicians Network contracts with MediCopy Services, Inc. to provide release of information services from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statute. You may visit http://www.odh.ohio.gov/ . By signing this authorization, you are **agreeing to pay MediCopy Services, Inc. for any duplication fees or charges** at the time of service or when applicable. **Questions regarding your invoice may be answered at 866-587-6274.**
- Unless withdrawn, this consent will **expire 180 days** from the date signed unless another date or event is specified. _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Appointed Representative Date

_____ _____
Witness Date

The fee schedule for a patient's personal representative (Durable Healthcare Power of Attorney, Parent or Legal Guardian):

- No records search fee
- For data recorded on paper:
  - $3.35 per page for the first 10 pages
  - $0.70 per page for pages 11 through 50
  - $0.28 per page for pages 51 and higher
- For data recorded other than on paper (i.e. -rays, MRI, or CAT scan, recorded on paper or film):
  - $2.30 per page
- Actual cost of postage