21135 Whitfield Place #107 • Sterling, VA 20165
(703) 421-7000 • fax (703) 430-4830

Medical Records Release Policy and procedure!

Please complete form, incomplete will result in delay in processing

New patient or wishing for us to get your medical records from another office.

In response to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, physicians have been faced with greater complexities when releasing medical records. In an effort to protect patient confidentiality, as well as comply with government regulations, Sterling Family Practice has developed policies and procedures to insure that your confidential medical records are handled in a manner meeting all necessary guidelines.

Medical Records will be released only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act.

Sterling Family Practice will only release records that were created and maintained by our doctors and clinic. We will not release records received from other clinics or providers.

The requirements for a valid authorization to release medical records are:

- In writing, dated and signed by patient
- Specifically identifies patient
- Specifically identifies the healthcare provider who is to make the disclosure
- Specifically identifies the information to be disclosed

Note: *an authorization which affects a medical record in which information concerning the performance or results of HIV (AIDS virus), STD testing, substance abuse, and mental or psychiatric treatment must specifically authorize the release of such test and/or treatment information or it will be excluded from the records release.*

- Specifies the name, address and institutional affiliation of the person or entity to whom the information is to be disclosed

Except for authorizations to provide information to third-party payers, authorizations are valid for 2 years.

Revocation must be in writing; an authorization can be revoked at any time unless:

- Needed to secure payment for services rendered; or
- Other substantial actions have been taken in reliance on the authorization (e.g. a claim has been made under a life insurance or disability policy)

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GUIDELINES FOR COMPLETION OF AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM STERLING FAMILY PRACTICE

1. This form can be used to release medical records from your previous provider.

2. You can fax the release form to your previous provider to release record to SFP.
   - Or we can fax your request on your behalf to your previous provider to obtain your medical records.

3. Complete the patient's name, daytime phone #, and date of birth.

4. Complete the name and address of the person/facility that the records are to be released to.

5. Check the reason for releasing this information (Purpose of this Disclosure).

6. Identify the appropriate dates of service for the records that are to be released.

7. Have your previous provider fax your medical records to 703-430-4830

Please note that your received Medical Records will be scanned to your existing Medical Record

8. Check the appropriate information that is to be released (copied and/or faxed).

9. Obtain the patient or legal representative's signature (relationship) and date.

10. If this request relates to AIDS/HIV, Mental Health Care, Alcohol/Drug Use, or Development Disabilities, please check box, sign and date under the specified section.

HealthPort®

HealthPort eDelivery

HealthPort eDelivery for the secure and expedient electronic transfer of protected health information

The HealthPort® Release of Information (ROI) process and functionality enables your facility to log and capture images of medical records and securely transfer them through our state-of-the-art confidential electronic portal HealthPort*Connect*™. No matter where you are in the electronic continuum (paper, hybrid or 100 percent electronic), we facilitate the successful electronic delivery of protected health information (RHI) to requesters.

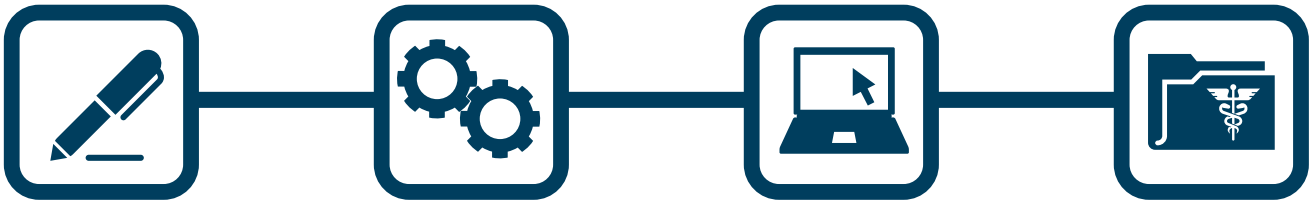
Streamlined Process for Secure Electronic Delivery:

1. **Request** – Patient completes a HIPAA-compliant request for medical records at your facility and provides an email address where an availability notification can be sent.
2. **ROI Process** – HealthPort ROI℠ staff logs and verifies the request, then retrieves the requested medical records and digitally captures the documents into HealthPort*Connect.*
3. **Notification** – The patient receives an email with instructions detailing how to access their records through HealthPort*Connect.*
4. **Retrieve** – The patient accesses HealthPort*Connect*, to retrieve their records. Easy-to-follow instructions allow patients the ability to view, print and save copies of the requested records.

Meeting a Meaningful Use Core Objective with HealthPort

Our time-tested processes and Meaningful Use (MU) certified eSmartlog®* technology, the logging, tracking and reporting component of our ROI software offering, provides an accelerated turnaround time, reduces costs associated with postage and paper and helps you meet the following Meaningful Use requirement:

> *Upon request, provide patients with electronic copies of their health record. For hospitals, at least 50 percent of the electronic copies must be provided within three business days of the request and include, at a minimum, diagnostic test results, problem list, medicating list, medication allergies, discharge summary and procedures.*



Patient provides email address when requesting record

Request is facilitated through the HealthPort ROI Process

Record available via HealthPortConnect

Patient retrieves record electronically

2011-2012 Drummond certified ONC-ATCB EHR MODULAR

*This EHR Module is 2011/2013 compliant and has been certified by Drummond Group, an ONC-ATCB approved to certify any complete or modular EHR both ambulatory and inpatient, in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments. HealthPort eSmartLog, 08/11/2011, Version 1.1, 08112011-1318-8 (inpatient), 08112011-1317-8 (ambulatory), 7zip

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name			
	First	Last	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip

Email Address for record delivery

Medical Records Requested			
Patient Name			
	First	MI	Last
Date of Birth			
Date of Service			
	From	To	

Please provide me with the medical records described above through the HealthPort eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's **eDelivery** website.
- I will receive an email from **HealthPort.com** containing instructions for accessing my records.
- If I do not retrieve my records within 30 days, they will be deleted.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date**:** _____

Sarah Fletcher, MD
Elizabeth Zapp, MD
Ilana Seidel, MD
Cynthia Yew, FNP-BC
Jessica Scalzo, FNP-BC

SFP
Sterling Family Practice

21135 Whitfield Place
Suite 107
Phone: (703) 421-7000
Fax: (703) 430-4830

www.sterlingfamilypractice.com

Authorization for Release of Medical Information

_____ _____
Print Patients Full Name Date of Birth

_____ _____
Street Address Social Security Number

_____ _____
City/State/Zip Code Home Phone Number

At the request of, I_____ do hereby authorize to release the following:
(check all that applies)

☐ Discharge Summary
☐ History & Physical
☐ Progress Notes
☐ Pathology Reports
☐ Laboratory Reports
☐ Radiology Reports
☐ Emergency Reports
☐ Other _____

☐ I do ☐ I do NOT authorize 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.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: _____
_____
_____

PLEASE RELEASE INFORMATION TO: _____
_____
_____

PURPOSE OF DISCLOSURE:

☐ Referral to Specialist
☐ Legal Investigation
☐ Other (please specify) _____
☐ Insurance
☐ Personal
☐ Workers Comp
☐ Continuing Care
☐ Change of Doctor/Provider
☐ Disability Determination

Note: There may be a charge for a personal copy or the permanent transfer of your records as follows: A $10.00 base fee, $0.50 per page for pages 1-50, then $0.25 for any pages over 50.

Please provide the best 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 authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual, Guardian or Legal Representative **Date**

Submit **Print** **Reset**