


Provide the release form and the letter below to all health care providers that hold your records. Under HIPAA you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason. [Note: HIPAA also allows you to request a summary of your medical records. If you prefer a summary, you should agree to a fee beforehand.]  Print

Medical Records Release

Form Letter

First Name*	Last Name*	Date Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address*	Doctor Name*	
<input type="text"/>	<input type="text"/>	
Home Address*	City*	State*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Zipcode/Postcode*	Country*	
<input type="text"/>	<input type="text"/>	
Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Slide 1
 Text Captions: The Medical Release section contains * Required fields and template letter that can be customized with your information. Together these forms should contain all the information needed to allow the release of your medical records.

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Email Address*	Doctor Name*	
<input type="text"/>	<input type="text"/>	
Home Address*	City*	State*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Zipcode/Postcode*	Country*	
<input type="text"/>	<input type="text"/>	
Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	

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Slide 2

Text Captions: Clicking on the "Letter" tab will allow you to review and edit the template letter.

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Medical Records Release

Form **Letter**

[Your name]
[Your address]
[Date]

[Name of care provider or facility]
[Address]

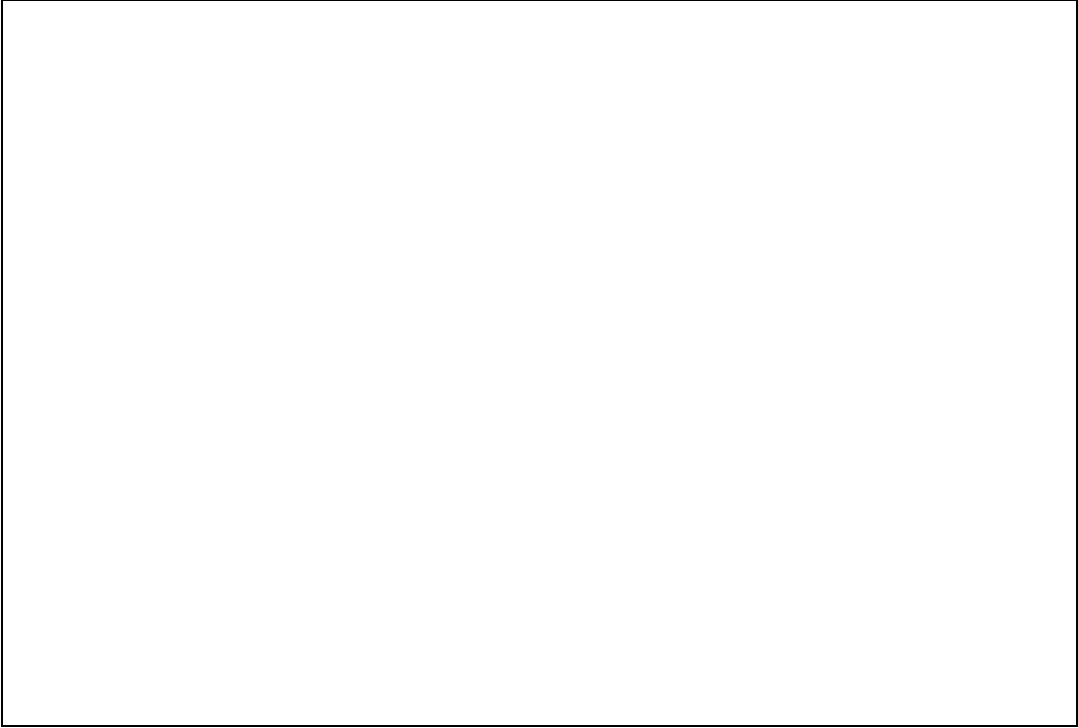
RE: [Your medical identification number or other identifier used]

Dear

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated in your office [at your facility] between [fill in dates]. I request copies of the following as marked on the attached regarding health records related to my treatment.

Slide 3
Text Captions: Move your mouse down to [Your name], then click and drag to highlight the text. Start typing your Name, continue down the letter entering your information.



Slide 4

Provide the release form and the letter below to all health care providers that hold your records. Under HIPAA you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason. [Note: HIPAA also allows you to request a summary of your medical records. If you prefer a summary, you should agree to a fee beforehand.]



Medical Records Release

Form **Letter**

[Your name]

[Your address]

[Date]

[Name of care provider or facility]

[Address]

RE: [Your medical identification number or other identifier used]

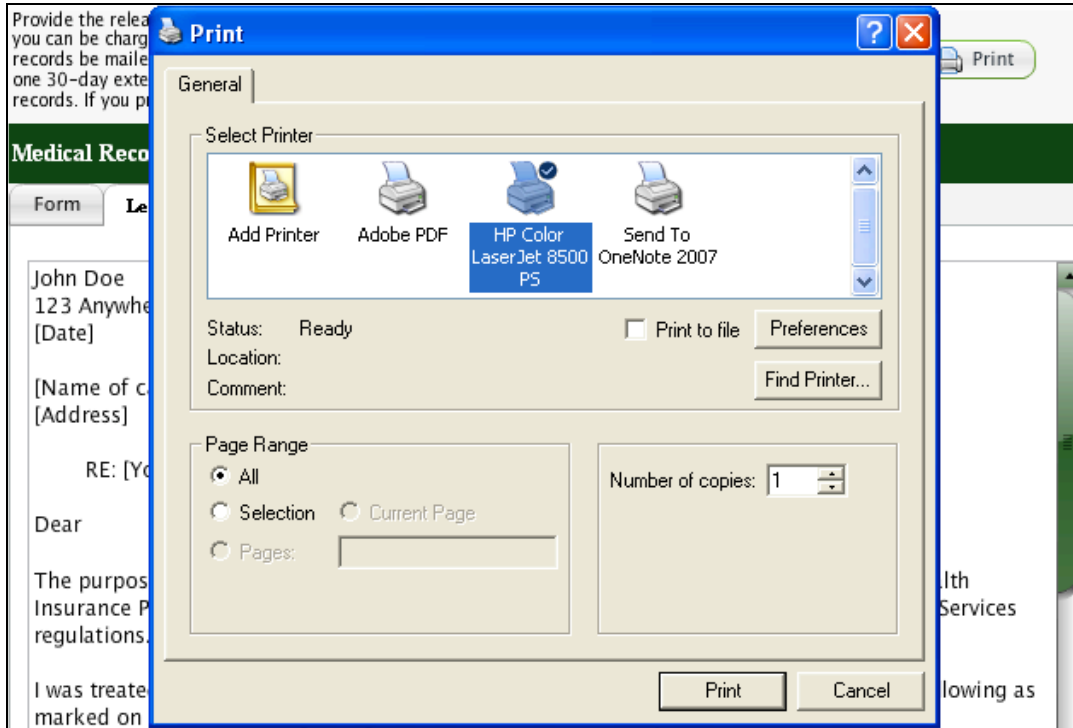
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I was treated in your office [at your facility] between [fill in dates]. I request copies of the following as marked on the attached regarding health records related to my treatment.

Slide 5

Text Captions: Once you have completed the form and letter, click Print



Slide 6
Text Captions: The Print dialog opens
Click the Print button