HEALTHMARK GROUP

Questions? Contact us at:
(800) 659-4035
status@healthmark-group.com

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION

Patient's Name	Date of Birth
Phone	**Email**

I AUTHORIZE THE RELEASE OF INFORMATION FROM

Provider/Facility: **Philadelphia Hand to Shoulder Center**

Phone **610-768-5940**

PHILADELPHIA HAND TO SHOULDER CENTER

I AUTHORIZE THE RELEASE OF INFORMATION TO

Person/Company	Phone
Address	Fax #
City,ST,Zip code	**Email**

DETAILED INFORMATION ON THE RELEASE

Dates of Service (Check One and Complete Dates of Service if Required)

o Please provide a complete copy of my file for **all** dates of service

o Please provide a complete copy of my file for service **from** _____ **through** _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

o Entire Chart o Office Notes o Consults o Lab Reports o Radiology Reports
o Imaging Films o Medications o Immunizations o Operative Reports o Physical Therapy
o Itemized Billing o Other _____

Purpose for Disclosure

o Continuing Care o Transfer of Care o Referring Physician o Disability
o Legal/Attorney o Insurance o Other _____

Please indicate your acceptance by checking the following boxes:

o I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

o I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

o I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)

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Patient Instructions for Medical Record Requests

Philadelphia Hand to Shoulder Center has partnered with HealthMark Group to ensure the accurate and timely completion of medical record requests.

How?
Requests may be submitted electronically to HealthMark's Request Manager at https://requestmanager.healthmark-group.com. Once logged in, select "Submit Request" from the menu options and enter all required fields to provide an authorization directly to HealthMark. Your medical record request will be processed, and a notification will be sent via mail or email once complete and available for download.

Requests may be submitted via fax to HealthMark's Request Manager at **800-833-5935**

Any questions?
Please log in to Request Manager for status updates or to chat with support. If you have any questions, you may contact HealthMark at 800-659-4035 or status@healthmark-group.com.