National Integrated Health Associates

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CONSENT FORM FOR THE RELEASE OF MEDICAL RECORDS

Records Released from NIHA

I authorize release of medical records on:

_____

Patient Name **DOB** **SSN**

Name at time of service if different than above: _____

Fee schedule: $25.00 for a maximum of 50 pages; $50.00 for 51 -100 pages; and $75 .00 for over 100 pages. Records over 50 pages will be sent via UPS. All other records are sent US mail unless other arrangements made with staff. Records will be sent at a maximum of 30 days although most charts are sent within 2 weeks.
Note: No original records are sent--only copies of records are sent since the original chart is the property of NIHA.

Complete record request:

☐ I wish to have copied the entire record generated by the **specific physician(s) or practitioner(s)** noted here **(print name(s)** in the following space) _____.
I understand that only those records generated by this specific physician(s) or practitioner(s) or as a result of procedures that he/she ordered will be released, and that records generated by other physicians or practitioners at NIHA or by other providers whose records were provided to NIHA will be not copied.

☐ I wish to have the **entire NIHA record** copied. I understand that only those records generated by NIHA physicians and practitioners or as a result of their orders will be released, and that records generated by other physicians whose records were provided to NIHA will be not copied.

Selected record request: I am only asking for the selected records noted below:

☐I only want the records for these dates of service: _____

☐I only want the following records:

☐ Laboratory studies ☐ Radiology studies (CT, MRI, x-ray, ultrasound)

☐ Narrative reports ☐ Other: _____

Please forward records to:

_____
Name of Person

_____
Address

_____
Fax Number **Telephone Number**

_____ _____
Signature of Patient or Legally Responsible Party **Today's Date**

This authorization will expire one year from the date of this signed copy. I understand that I can revoke this authorization in writing at any time, though revoking this authorization will not affect disclosures made prior to notice of such revocation. I understand that I am entitled to a copy of this authorization and that a copy will be as effective as the original.

Staff: Date Form Rec.	/Fee Paid	/Fin.Rev.	/MD Rev.	/Mail Date	/Person Resp.

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