TCPC
TRI-COUNTY PAIN CONSULTANTS, PC

Dear Valued Patient,

Thank you for your request for information from your medical record. We appreciate the opportunity to service your *release of information* medical record request. As you can hopefully understand, the cost for the reproduction of medical record requests is quite extensive. In addition, we are bound by HIPAA (Federal Privacy Act) to track and report each request. Therefore, in order to fulfill your request, we must ask for an upfront fee according to Michigan State Law **paid directly to our medical records partner, BACTES Imaging Solutions. They will send you an invoice for pre-payment.** This fee is geared to off-set the rising costs associated with the copying, tracking and reporting processes surrounding your request.

Tri-County Pain Consultants, PC is capping the fee at $25.00 for a five-year abstract of your record. If you want more than the five years of information, the fee is capped at $50.00. At no time, will your charges exceed the allowable Michigan statute.

Should you have any questions regarding the fee, please contact Bactes at 248-977-3926. Thank you again for your confidence in Tri-County Pain Consultants, PC.

Sincerely,

Tri-County Pain Consultants, PC Medical Records Department

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Please print all information. Form must be signed and dated each year.

Name:_____ **Date of Birth:** _____

SSN (last four digits): _____

Entity Requested to Release Information:

_____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.
Who will be authorized to receive information (list the individual/entity that is to receive my PHI):

Individual/Entity Name_____Phone_____

Address: _____

_____

Description of information to be disclosed (select 1, 2, or 3 below) - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

- ☐ Please provide my 5 year history ($25 or MI statute, whichever is less)
- ☐ Please provide my entire record ($50 or MI statute, whichever is less)
- ☐ Please provide only the following (fees based on MI statute)
  - ☐ Office notes
  - ☐ Lab reports
  - ☐ X-ray and MRI reports
  - ☐ Operative reports
  - ☐ Physical therapy reports

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (Please Specify):_____

- I approve, to the extent it exists in my records, the release of the following information: mental health (as addressed in 45CFR 164.501); alcohol abuse; substance abuse; AIDS; HIV; sexually transmitted diseases; rape and sexual abuse
- This authorization will expire 12 months after the date of my last signature below, unless I specify an earlier termination. I must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than 12 months_____
- I have the right to terminate this authorization at any time by submitting a written request to the Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- The practice has no control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient Signature date

_____ _____
Representative Signature date

_____ _____
Representative Printed Name date

You have the right to receive a copy of signed authorizations upon request.

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The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Social Security Number - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Sensitive Information – This provides the ability to release all the information in your records

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Re-disclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The re-disclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.