Medical Records Process

You must complete the AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION.

You will need to include an original or copy of one form of picture identification such as a driver's license, passport, or military identification card.

If you are not the patient, you must also provide a copy of your own picture identification. You must also indicate your relationship to the patient & attach your supporting authorization or legal documentation for obtaining or requesting the Medical Records.

For your convenience, we provide different ways to request a copy of your medical records. Requests and documentation may be submitted in person, by mail, or via fax:

Madison Primary Care
3776 Sullivan St, Suite D
Madison, AL 35758
Phone - 256-774-5524
Fax - 256-774-5523

Medical Records Fees

Fees are regulated by Alabama state law and will apply to support staff time & resources dedicated to this service.

Alabama State Cost of Reproduction and Delivery of Medical Records

- $5.00 Search Fee
- $1.00 per page for pages 1-25
- $0.50 per page for 26 and up;
- Estimated cost of actual postage

Medical Records Release Types

For Continued Care to Physicians

Fax Transfer FEE: None
Photo ID & Completed Authorization Required. These faxed records will be provided as a professional courtesy at no charge. Our standard duration of records to release is 2 years of clinic notes, testing and operative notes unless otherwise noted. The requested records will be released through a secure fax.

For Personal Use

COPY FEE: Yes
Photo ID & Completed Authorization Required. Once the request is received and completed, the patient will be notified when records are ready. Medical records fees must be paid with submission of the request, or prior to release.

For Insurance Purpose

COPY FEE: Yes
Photo ID & Completed Authorization Required

1) If the patient requests records for insurance purposes, they are responsible for the copy charges. The patient will need to pick up and provide the records to their insurance company, or specify how they wish the records to be sent.

2) If the Insurance Company requests the records, we must receive the request in writing from the Insurance Agency with a signed patient authorization. The agency will be notified of the copy charges and when the request is complete.

AUTHORIZATION FOR USE/DISCLOSURE OF PATIENT HEALTH INFORMATION

1. I authorize Madison Primary Care to disclose and/or receive the following information for the below patient:

Patient's Name: ______________________ Date of Birth: ______________________

Chart ID #: ______________________ Phone #: ______________________

Address: ____

City/State/ZIP: ____

2a. I AUTHORIZE:	2b. TO RELEASE TO:
______________________ Name of Sending Person/Organization	______________________ Name of Receiving Person/Organization
______________________ Street Address	______________________ Street Address
______________________ City, State, ZIP Code	______________________ City, State, ZIP Code
______________________ Phone # Fax #	______________________ Phone # Fax #

3. Requested Delivery Method

❑ Electronic Fax ❑ Mail ❑ Pickup ❑ Other/Specify:______________

4. At my request, the following information may be disclosed or used: (specify dates where needed)

❑ Medical record (last two years) ❑ Medical record Date(s):______________

❑ Immunizations Date(s):__________ ❑ Laboratory results Date(s):______________

❑ HIV/AIDS test results Date(s):________ ❑ Mental health record Date(s):______________

❑ Other records specify type:__________ ❑ Other records specify date(s): ______________

5. For the purpose of: (check all that apply)

❑ Continuity of care ❑ Personal use ❑ Consultation ❑ Insurance claim

❑ Form completion ❑ Attorney inquiry ❑ Social Security ❑ Workers' comp

❑ Eligibility/enrollment ❑ Life Insurance ❑ Employer request ❑ Appeals

❑ Other (please specify) ____

6. I understand that the information released upon authority of this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, HIV/AIDS test results, diagnoses or treatment of HIV/AIDS, and past medical history information.

7. This authorization will expire 60 days from the date of signing. I understand that I have a right to revoke this authorization at any time by submitting my written revocation to Madison Primary Care. I understand that the revocation will not apply to any actions taken in reliance on this authorization.

8. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and is not protected by the practice's policies or the HIPAA Privacy Rule.

9. I understand that a reasonable fee, as mandated by state law, will be charged for duplication of records and accept full financial responsibility for that fee.

10. I understand that I (or authorized representative) am entitled to a copy of this authorization.

By signing this form below, you are authorizing the release of the requested information identified above. If the person signing is not the patient, indicate the relationship to the patient and attach supporting authorization or legal documentation.

____ ____________________

Signature of Patient or Authorized Representative — Date

____ ____________________

Patient or Authorized Representative's Name (printed) — Relationship to Patient

---

Internal Use: Type of Identification Provided

❑ Drivers License #:_______________ ❑ Passport #:______________________________________

❑ Military ID #:__________________ ❑ Other ID # (Specify Type): ___________________________

❑ Expiration:_____________________ ❑ Issuing State/Country: ______________________________

❑ Authorized Personal Representative supporting authorization or legal documentation details:

____

MPC Staff Signature: ________________________________ Date: ______________________