MediCopy

VALLEY ORTHOPAEDIC SPECIALISTS

Medical Record and Form Completion Information

MediCopy is a health information management company that has partnered with your healthcare facility to to fulfill your Release of Information requests as well as your Disability/FMLA paperwork.

Here's What to Expect:

1) Sign an authorization form or turn in your Disability/FMLA paperwork at your healthcare facility. Please provide an email address if available as this will expedite the process.

2) Your healthcare facility will forward your request or paperwork to MediCopy for completion. If payment is required you will receive an invoice via email.

3) If you need to submit when you are not at the healthcare facility please visit www.medicopy.net/patients.

If you have any questions, please contact MediCopy

online chat: MediCopy.net

toll-free phone: 866.587.6274

MediCopy is fully HIPAA compliant and adheres to all state and federal regulations regarding your protected health information.

MediCopy Authorization for the Release of Medical Records

Where are the records being released from?

Facility Name: Provider Name(s):

Address: City: State:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released? Check all that apply.

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ Psychological/Psychiatric, if any

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records ☐ Substance Abuse, if any

☐ Dates _____ to _____

☐ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Pick-up at MediCopy ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient:

Send to: MediCopy Services, Inc. 8 City Blvd., Ste 400 Nashville, TN 37209 • P: 615-780-2741 F: 615-780-9866 • request@medicopy.net