reno orthopedic clinic

MEDICAL RECORD
RELEASE OF INFORMATION AUTHORIZATION

Instructions for Requesting Medical Records

Reno Orthopedic Clinic has retained a professional service to handle the duplication and transfer of medical records. The company performing these services is:

DataFile Technologies
4100 N Mulberry Dr., Suite 300
Kansas City, MO 64116
Phone: 816-437-9134
Email: status@datafiletechnologies.com
Web: www.datafiletechnologies.com/records

In order to standardize and expedite all requests for patient information, please follow the process below:

1. Sign, date, and completely fill out the **Medical Record Release of Information Authorization** provided to you. **Include your phone number and complete address** on your request in the event there are any questions regarding the release of your records.
2. Submit your signed and COMPLETED Medical Record Release of Information Authorization to the Front desk or mail to the above address
3. Records will be delivered By Electronic Delivery unless otherwise indicated on the Medical Record Release of Information

Authorization – some records MAY have a fee for delivery.
DataFile collects all fees due when applicable.

Records are available via secure email.
Questions regarding secure email? Contact DataFile @ 816-437-9134.

In order for your request to be processed, please be sure to fill out all fields on the medical records release form. Your request may be delayed if DataFile cannot determine:

- **Who you are** – Your name, DOB, and address
- **What records need to be sent** – What records, specifically the dates of service or body parts examined
- **Where you would like the records sent** – Complete address of where the records are to be delivered, in addition to a fax number if you would like them to be faxed
- **Your signature and when you signed the Medical Record Release of Information Authorization** – You must sign and date the form in order for it to be valid.

Your request will be completed within 10 days of receipt of the request. If you request only the electronic portion of your chart, you may receive your information faster

If you have questions on the process of completing this form, contact DataFile.

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WHO

Patient Name: _____ Date of Birth: ____/____/____ SSN #: (last 4) _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

FROM

I hereby authorize records FROM:

Name: _____ Address, City, State, Zip: _____

Phone:_____ Fax: _____

TO

To be released TO:

Physician Name/Facility/Self (Self for personal copies): _____

Address: _____

City, State, Zip: _____ Phone:_____

HOW

Delivery options: ☐ Pick-Up @ 555 N. Arlington Ave Reno NV 89503

☐ E-mail: _____

☐ Fax: _____ ☐ Mail ☐ CD (Radiology Images only)

Paper requests can take additional 3-5 business days for processing.

WHAT

Date of Service: From ___/___/____ To ___/___/____ ☐ All Dates of Service

☐Physician Office Note ☐Operative/Procedure Reports ☐Radiology/X-ray/MRI Reports

☐Lab/Path Reports ☐ Personal ☐ 2nd Opinion ☐ Other specified: _____ ☐ All

WHY

Purpose of Disclosure: (Please select one)

☐Referral to Specialist ☐Transfer of Care ☐Insurance ☐Workman's Comp ☐Legal Investigation

☐ Disability Determination/Claim ☐ Personal ☐ 2nd Opinion ☐ Other:_____

SIGNATURE

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

*This release expires one year from date signed unless I specify an expiration date: _____.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Name/Authorized Representative: _____

Patient Signature/Authorized Representative: _____ Date ____/____/____