

***Instructions for Requesting Medical Records***

**\*\*All Health Records are available to be forwarded, printed or download in MyChart\*\***

Should you choose to still submit a formal records request, Reno Orthopedic Clinic has retained a professional service to handle the duplication and transfer of medical records. The company performing these services is:

**ScanSTAT Technologies**  
**4100 N Mulberry Dr., Suite 300**  
**Kansas City, MO 64116**  
**Phone: 816-437-9134**  
**[status@scanstat.com](mailto:status@scanstat.com)**

**You can also submit your requests or check status online at:**

**<https://www.scanstat.com/check-records-request-status/>**

**In order to prevent any delays in processing and expedite all requests for patient information, please follow the process below:**

**\*\* Incomplete form requests will not be completed\*\***

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 via Secure Email unless otherwise indicated on the Medical Record Release of Information.

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

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 ScanSTAT cannot determine:

- **Who you are** – Your name, DOB, and/or 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 bottom of 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, please contact ScanSTAT.**

**MEDICAL RECORD  
RELEASE OF INFORMATION AUTHORIZATION**

<b>WHO</b>	Patient Name: _____ Date of Birth: ___/___/___ SSN #: (last 4) _____ Patient Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) ____-_____
<b>FROM</b>	<b>I hereby authorize records FROM:</b> Name: _____ Address, City, State, Zip: _____ Phone: _____ Fax: _____
<b>TO</b>	<b>To be released TO:</b> Physician Name/Facility/Self (Self for personal copies): _____ Address: _____ City, State, Zip: _____ Phone: _____
<b>HOW</b>	<b>Delivery options:</b> <input type="checkbox"/> Pick-Up @ 555 N. Arlington Ave Reno NV 89503 <input type="checkbox"/> E-mail: _____ <input type="checkbox"/> Fax: _____ <input type="checkbox"/> Mail <input type="checkbox"/> CD (Radiology Images only)
<b>WHAT</b>	<b>Date of Service:</b> From ___/___/___ To ___/___/___ <input type="checkbox"/> All Dates of Service <input type="checkbox"/> Physician Office Note <input type="checkbox"/> Operative/Procedure Reports <input type="checkbox"/> Radiology/X-ray/MRI Reports <input type="checkbox"/> Lab/Path Reports <input type="checkbox"/> Personal <input type="checkbox"/> 2nd Opinion <input type="checkbox"/> Other specified: _____ <input type="checkbox"/> All
<b>WHY</b>	<b>Purpose of Disclosure:</b> (Please select one) <input type="checkbox"/> Referral to Specialist <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Workman's Comp <input type="checkbox"/> Legal Investigation <input type="checkbox"/> Disability Determination/Claim <input type="checkbox"/> Personal <input type="checkbox"/> 2nd Opinion <input type="checkbox"/> Other: _____
<b>SIGNATURE</b>	<p>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.</p> <p>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.</p> <p>*This release expires one year from date signed unless I specify an expiration date: _____.</p> <p><b>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.</b></p> <p>Patient Name/Authorized Representative: _____</p> <p>Patient Signature/Authorized Representative: _____ Date ___/___/___</p>

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