John Alchemy MD

Send Completed form to: Records@johnalchemymd.com

JOHN ALCHEMY MD CORP
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information:
Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email Address: _____

I hereby authorize John Alchemy MD Corp to release my medical information as described below:

Information to be Released:
□ Entire Medical Record
□ Laboratory Reports
□ Imaging Reports
□ Immunization Records
□ Other: _____

Purpose of the Release:
□ Personal Use
□ Continuation of Care
□ Legal
□ Insurance
□ Other: _____

Recipient Information:
Name: _____
Organization: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Information will be released in PDF format on an unsecured USB Drive. I understand and consent to this.

MEDICAL RECORDS RELEASE FEE DISCLAIMER
I hereby acknowledge and understand the following terms related to the request for the release of my medical records from [Medical Practice/Provider's Name]:
Copy Fees: A service fee of $25 for electronic; If hard copy requested an additional charge of $0.25 per page. Page fees are calculated based on file MB size.

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Right to Assign: I have the right to assign the request for copies of my medical records to a formal copy service. Upon my assignment, the copy service will be responsible for obtaining the medical records on my behalf.
Copy Service Fee Limitation: When a formal copy service is assigned to request and obtain my medical records, the copy service will be charged a fee not exceeding $15 for the service. This fee applies to the service conducted during a visit to the clinic by appointment arranged specifically for this purpose.
Appointment for Copy Service: I understand that the formal copy service must visit the clinic by appointment to obtain the medical records. It is my responsibility or that of the assigned copy service to arrange this appointment in accordance with the clinic's policies and availability.

By signing this disclaimer, I confirm my understanding and agreement to the aforementioned fees and conditions associated with the release of my medical records. I acknowledge that these fees are in compliance with applicable laws and regulations governing the release of medical records.

Expiration of Authorization:
This authorization will expire one year from the date of signature unless otherwise specified:
Expiration Date: _____

Right to Revoke:
I understand that I have the right to revoke this authorization at any time by submitting a written notice to John Alchemy MD Corp, except to the extent that action has already been taken based on this authorization.

Signature:
By signing below, I acknowledge that I have read and understand this authorization form. I am aware of my rights and the implications of this authorization.

Patient Signature: _____ Date: _____

If the patient is a minor or unable to consent:
Relationship to Patient: _____
Signature: _____ Date: _____

FOR OFFICE USE ONLY
Date Received: _____
Processed By: _____
Date Processed: _____
Amount Due: $_____
Date Payment Received:_____
Notes: _____