New Era General Services, Inc

HIPAA & CMIA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

RE: Patient Name: _____

Date of Birth:_____Social Security Number: _____

Email _____ Tel _____

Fax _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

By signing authorization you agree to pay the following fees for records.
Please check box of delivery method.

☐ $16.00 Fee Plus $0.10 Per Page & $2.99 electronic processing fee. Records will be provided via HIPPA Compliant secure electronic download.

_____
Signature of Patient or Legally Authorized Representative

_____
Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____
Date