Franklin Medical GROUP, PC

MEDICAL RECORDS POLICY

Medical Record Duplication and Form Completion

It is the policy of the Practice to routinely charge a fee to cover the duplication expenses involved in the transfer of records outside the system and for the completion of forms requested by outside entities. The Administrator evaluates the fees presented in this policy annually to ensure that they are reasonable, based on the Practice's cost, and that they comply with fees set by individual states. The fee can only include the cost of:

- Copying, including the cost of supplies and labor, up to a maximum per page fee, if required by state law; and
- Postage, when the individual has requested the copy be mailed.

It is critical that charges are handled in a standard manner throughout the system, including billing of the requesting party, who is responsible for the payment of such fees. In general, all requested material (i.e., the entire record) should be produced if requested; consult with the Administrator or legal counsel if there are questions. If a summary report is requested, there is a reasonable fee as established by the Practice for preparation of this report.

PROCEDURES

1. Patients may request that their medical records be sent to them, and/or transferred to another provider or a third party. That request is honored only after a signed release of information form is completed at the Practice. (See attached)
2. If a patient requests a copy of their medical records, the patient is to pick up the medical records at the office. If the patient requests it be mailed, this must be noted on the signed authorization.
3. Advise the requestor that there may be a fee for copying of the patients medical records of .65 cents per page, not including postage (if applicable).(This excludes a patients request for medical records to transfer within the Health System)
4. After the patients records are counted, the medical records clerk completes an invoice.
5. The medical records clerk then advises the requestor that the records are ready for pickup and a fee of due before records can be released.
6. Log the request on the medical records release form attached.

a) The medical records release form should be kept in a binder located in the medical records room. All staff copying records should have access to this binder and be informed of the process.

7. Forward a copy of the request along with the FMG invoice and money in an inter-office envelope to: Controller, Franklin Administration.

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Practice, or any of its authorized employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient name: _____

Address: _____

(Street) (City) (State) (ZIP)

Date of birth: _____ Account #: _____

Date(s) of treatment: _____

Release information to: _____

(Name of individual or organization)

_____

Address: _____

(Street) (City) (State) (ZIP)

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care

*requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Specific Records (date range)

_____ Entire medical record

_____ Other: _____Labs _____Slides** _____X-rays**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment _____ Litigation for review

_____ Insurance (company name): _____

_____ Other (specify reason): _____

This consent permits the Practice to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ (Print patient's name)

_____ (Signature of patient) Date: _____

_____ (Signature of legally authorized person)

A request may take several working days to process. If there are questions, please contact the Office Coordinator at [203-709-5935].

Office Use Only: Franklin Medical Group Internal Use

Current Office on EHR:	Yes____	No___
Transfer to Office on EHR:	Yes____	No___
Office notified via EHR messaging:	Yes____	No___

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INVOICE

MEDICAL RECORDS REQUEST

PETITIONER:

Name_____ **REQUEST DATE:** _____

Address_____

City, State, ZIP_____

PATIENT:

Name_____

DOB_____

DATE(S) OF SERVICE: _____

ATTENDING PHYSICIAN(S): _____

Quantity	Description	Unit Price	Amount
	Administrative fee for photocopying of medical records @ .65 per page X_____ pages.	**$0.65**	**$ _____**
		+	
	Postage	**$0.45 per oz**	**$ _____**
		PAY THIS AMOUNT	**$**

MAKE ALL CHECKS PAYABLE TO: Franklin Medical Group, PC

MAIL TO: _____

_____

Please note: These records are for DOS performed within Franklin Medical Group. Although we are able to provide you with billing records, you will need a separate request for St. Mary's Hospital medical records.

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MEDICAL RECORDS POLICY

Signature Log

It is the policy of the Practice to maintain a log of signatures and initials of all personnel who document information maintained by the Practice. Documentation includes, but is not limited to, medical records, interpretations of test results, and telephone messages.

PROCEDURES

1. A signature log is kept in the medical records filing area for the purpose of identifying any signatures placed in the medical record, or any document that is scanned and included in the record.
2. Every Practice employee and provider who is documenting is required to record his or her name and initials in the log. Every new employee and provider writes his or her signature and initials in this log as part of the orientation process.
3. It is the overall responsibility of the Administrator to confirm that all Practice employees and providers follow these procedures.

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Medical Records Request Log For Practice

Date of Request	Patient Name	Requested By	Copied By (Initial)	Date Mailed/Faxed

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