

BUSINESS RECORDS MANAGEMENT LLC
RELEASE OF INFORMATION FORM
Authorization for Release of Health Information



MAIN MEDICAL

Please Fill Out Completely
(Please Print)

PATIENT INFORMATION

Patient's Name _____
(include previous/maiden name used, if applicable)

Patient's Date of Birth _____ Patient's Social Security Number _____

Patient's Address _____

City _____ State _____ Zip Code _____ Phone No. _____

DISTRIBUTION INFORMATION (Please choose one)

Certified Mail, please mail my radiology and/or mammograms to the following address (**if different from above**)

Person/Facility **RECEIVING** Information _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Pick up at **BRM - 923 Bidwell Street, Pittsburgh, PA 15233 location ONLY.**
Items can be picked up between 8:30 am and 4:30 pm Monday through Friday.
Note: Items will be available seven (7) business days after receipt of request.

TREATMENT and PURPOSE INFORMATION:

Radiology Film(s) ONLY Mammogram Film(s) ONLY Both Radiology and Mammogram

Include Date(s) of Service: _____

Treating Facility (please mark all that apply):

<input type="checkbox"/> MAIN Medical Corporate 2403 Sidney Street, Suite 220 Pittsburgh, PA 15203	<input type="checkbox"/> MAIN Medical Greensburg 1275 Main Street, Suite 202 Greensburg, PA 15601	<input type="checkbox"/> MAIN Medical West Mifflin 1907 Lebanon Church Road West Mifflin, PA 15122
<input type="checkbox"/> MAIN Medical Monroeville 600 Oxford Drive Monroeville, PA 15146	<input type="checkbox"/> MAIN Medical Harmar 3 Mariner Court Pittsburgh, PA 15238	<input type="checkbox"/> MAIN Medical Thorn Run 1136 Thorn Run Road Coraopolis, PA 15108

Airport Regional Medical Center

The **purpose** or need to disclose these records is (please choose one):

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Employer	<input type="checkbox"/> Insurance Coverage	<input type="checkbox"/> Legal
<input type="checkbox"/> Study/Research	<input type="checkbox"/> I wish not to disclose	<input type="checkbox"/> Other _____	

PAYMENT INFORMATION:

Certified USPS Mail Method:

If BRM will be distributing your film(s) via **USPS Certified Mail**, please mail your completed request and payment for **\$28.30** to:

Business Records Management LLC
Medical Record Correspondence - Mail
923 Bidwell Street
Pittsburgh, PA 15233

Patient Pick-up Method:

If you will be **picking up** your film(s) from BRM's facility, please mail your completed request and payment for **\$19.80** to:

Business Records Management LLC
Medical Record Correspondence – Pick Up
923 Bidwell Street
Pittsburgh, PA 15233

***Please make check or money order payable to Business Records Management LLC**

Note: The \$19.80 fee is **non-refundable** and covers search and retrieval of files. The \$8.50 fee covers certified postage and handling. Payment of these services must be made prior to the release of record(s). If choosing the mailing method (\$28.30) and the record is not located, a refund will be made in the amount of \$8.50

I hereby request and authorize Business Records Management LLC (BRM), on behalf of Main Medical (Customer Number 0107), to release my original radiology and/or mammogram films to myself at the above address or to the address provided beneath Distribution Information.

I have been a patient of Main Medical (Customer Number 0107), or am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person that I represent.

I fully understand that the contents of my radiology and/or mammogram films may contain information relating to my identity, diagnosis, prognosis and/or treatment. This may include, but not limited to, HIV, mental health, drug or alcohol abuse.

I have read and understand the nature of this release of information as indicated above. This authorization and request shall be valid **until the disclosure is complete or up to 90 days** after the date below, after which time it shall expire. **I understand that I may revoke this authorization in writing at any time up to the time this request has been fulfilled or any other action has been taken in reliance on this request by submitting in writing my revocation to the above named healthcare provider.** A photocopy or facsimile of this authorization will be considered valid as an original. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization.

I understand that, if persons or organizations I authorize to receive and/or use the protected health information described above, are not health plans, covered health care providers or health care clearing houses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

BRM and its subsidiaries, affiliates, employees and officers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also understand that the original radiology and mammogram films are being released and additional copies do not exist. Upon signature, you are entitled to a photocopy of this Authorization for the Release of Health Information form.

Patient Signature

Date Signed

(14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

Parent/Legal Guardian/Authorized Representative

Date Signed

Relationship to Patient