

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



MEDICAL NEUROLOGY ASSOCIATES

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 mail copies of my medical records to the following address (**if different from above**)

Person/Facility **RECEIVING** Information _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Note: Fulfilled requests will be distributed seven (7) business days after the photocopy & postage invoice is received at BRM.

PAYMENT INFORMATION

BRM will be distributing the copy of your medical record(s) via **USPS Certified Mail**, please mail your completed request and payment for **\$19.80** to:

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

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

Credit Card Payment Option:

Credit Card payments (Visa or MasterCard) can be made by downloading a credit card authorization form from our website www.businessrecords.com. The form can be found under Patient Information, Medical Neurology Associates.

If using this method, please be sure to mail the credit card authorization form with this form.

Note: The \$19.80 fee is non-refundable and covers search and retrieval of files. **Additional charges for the cost of photocopies & USPS Certified Mail cost (in accordance with Pennsylvania State Legislation) will be invoiced to the patient once those charges have been calculated.** Payment of these services must be made prior to the release of record(s).

Photocopying:	\$1.33/page (pages 1-20) \$0.99/page (pages 21-60) \$0.33/page (pages 61+)
Postage:	Actual Cost

I hereby request and authorize Business Records Management LLC (BRM), on behalf of Medical Neurology Associates, to release copies of my original medical records to myself at the above address or to the address provided beneath Distribution Information. BRM has only been authorized to release the complete copies of the entire medical record(s).

I have been a patient of Medical Neurology Associates, 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 medical record(s) 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. Upon signature, you are entitled to a photocopy of this Authorization for the Release of Health Information form.

Patient Signature

(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.)

Date signed

Parent/Legal Guardian/Authorized Representative

Date signed

Relationship to patient