

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



OPEN MRI OF ERIE

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 MRI film report and original MRI films to the following address (if different from above)			
Person/Facility RECEIVING Information _____			
Name _____			
Address _____			
City _____	State _____	Zip Code _____	
<i>Note: Fulfilled requests will be distributed ten (10) business days after the ROI & payment have been received at BRM.</i>			

PAYMENT INFORMATION

BRM will be distributing the copies of my MRI film report and original MRI film via USPS Certified Mail . Please mail your completed request and payment for \$9.02 to:	
Business Records Management LLC Medical Record Correspondence - OME 923 Bidwell Street Pittsburgh, PA 15233	
*Please make check or money order payable to Business Records Management LLC	
.....	
Patient Requests: The \$1.50 fee is non-refundable and covers search and retrieval of files, \$1.00 is applied to the photocopying up to 4 pages and \$6.52 covers the certified return receipt postage.	
Non-Patient Requests: Are charged in accordance with Pennsylvania State Legislation and will be invoiced to the requesting party once those charges have been calculated.	

I hereby request and authorize Business Records Management LLC (BRM), on behalf of Open MRI of Erie, to release copies of my MRI film report and **actual original MRI films** 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 MRI film report and the entire **original MRI film and jacket**.

I have been a patient of Open MRI of Erie, 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. I also understand that the original MRI 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

(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