UNITED MEDICAL
ACCOUNTABLE CARE ORGANIZATION

United Medical Accountable Care Organization
161 Becks Woods Drive, Bear, DE 19701
Care Coordination Team
Phone: 302-365-8333
Fax: 866-334-5338

Authorization for Release of Protected Health Information | Part 1

PATIENT NAME	DATE OF BIRTH
ADDRESS	SSN
CITY STATE ZIP	PHONE #

FROM:	**TO**:
Physician/Facility: ______________________________	Physician/Facility: ______________________________
Address: ______________________________	Address: ______________________________
Phone: ______________________________	Phone: ______________________________

INFORMATION TO BE RELEASED

- □ Complete Medical Record
- □ Recent H & P
- □ Lab Reports
- □ Radiology Reports
- □ Hospital Reports
- □ Last 3 Visits
- □ Other:

REASON FOR THIS REQUEST

- □ Transfer of Care (*Please provide a brief reason below*)
- □ Change in Health Insurance
- □ Patient Request (*Personal Choice*)
- □ Other:

METHOD OF DISCLOSURE

□ Pick Up (Name of Individual who will pick up your records):

____

□ Fax #: ______________________________

□ Mail to: ______________________________

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Description of information you **DO NOT** authorize to be disclosed if any: (Subject to Provider's approval)

***** PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS. *****

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Authorization for Release of Protected Health Information | Part 2

Patient Acknowledgement:

By signing below, I certify that:

- I understand that I may inspect a copy of the records being disclosed
- I understand that unless excluded and noted herein the information being disclosed may contain sensitive information such as sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, physical abuse, or treatment for drug and alcohol abuse and psychotherapy notes.
- I understand that this authorization will expire in 3 months following the date of this authorization.
- I understand that I may revoke this authorization at any time (except to the extent that the information was already disclosed on reliance on this signed authorization) by notifying the provider's office in writing.
- I understand that if the person or organization that receives information is not covered by privacy regulations, the information may be disclosed and would no longer be protected.
- **I understand that there may be a fee for copying/ supplying medical records. All ambulatory medical practices in the United Medical ACO follow the state regulations in regards to the fee schedule for copying charts.**
  - **$2.00 per page for pages 1 – 10**
  - **$1.00 per page for pages 11 – 20**
  - **$0.90 per page for pages 21 – 60**
  - **$0.50 per page for pages 61 and above**
- I understand that I have the right to receive a copy of this form.
- I understand that photo ID is required if the medical records are being picked up by another individual
- I understand that I will be contacted at the following number(s) when records are ready for release:
  - Phone: ___________________________________

I authorize the release of all information indicated. I release my current physician's office as previously stated above from all legal responsibility and/or liability that may arise from the release of the records I have specified.

______________________ PATIENT NAME	______________________ DATE
______________________ DATE OF BIRTH	______________________ ADDRESS
______________________ PHONE #	______________________ CITY STATE ZIP
X ______________________ PATIENT/PARENT/GUARDIAN/CAREGIVER SIGNATURE	______________________ RELATIONSHIP TO PATIENT