PATIENT & REFERRING PROVIDER FORM

Medical Records Request & Authorization

Authorization for release of protected health information (PHI) for treatment, continuity of care, and coordination of care. Complete Sections 1 through 3, then sign Section 11.

401 NORTH BEDFORD STREET · EAST BRIDGEWATER, MA 02333 · (781) 375-3150

1 Patient Information

PATIENT NAME

PREVIOUS / MAIDEN NAME (IF APPLICABLE)

DATE OF BIRTH

PHONE

ADDRESS

CITY / STATE / ZIP

2 Records Requested From

The provider, hospital, or facility that currently holds the records.

PROVIDER / FACILITY NAME

PHYSICIAN NAME (IF APPLICABLE)

ADDRESS

CITY / STATE / ZIP

PHONE

FAX

3 Release Records To

Inbound — the facility in Section 2 sends the requested records here.

ATTN: MEDICAL RECORDS / PRIMARY CARE

Nova Medical Group
401 North Bedford Street
East Bridgewater, MA 02333

PHONE	**(781) 375-3150**
FAX	**(781) 375-3146**
SECURE EMAIL	**documents@novamedicalgroup.net**
PURPOSE	Treatment, continuity of care, and coordination of care.

4 Records Released to Another Facility

OUTBOUND

Complete this section only when Nova Medical Group is **sending** records **out** to another facility. The rest of this form covers records we are requesting *in*.

A · SEND RECORDS TO

RECEIVING FACILITY / PROVIDER _____ ATTN / DEPARTMENT _____

ADDRESS _____ CITY / STATE / ZIP _____

PHONE _____ FAX OR SECURE EMAIL _____

B · RECORDS TO BE RELEASED

- ☐ Office visit / progress notes
- ☐ Laboratory results
- ☐ Imaging reports
- ☐ Imaging discs / actual images
- ☐ Cardiac testing
- ☐ Specialist consultation notes
- ☐ Operative / procedure & pathology reports
- ☐ Medication list · Allergies · Problem list
- ☐ Immunization records
- ☐ Other:

Date range: from _____ **to** _____ ☐ Most recent 2 years ☐ Complete record

C · REASON FOR RELEASE

- ☐ Continuing treatment / transfer of care
- ☐ At the request of the patient
- ☐ Insurance, legal, or other non-treatment purpose
- ☐ Other:

D · Patient Authorization to Release

I authorize **Nova Medical Group** to release the records identified above to the facility named above. I understand that this authorization is voluntary, that I may revoke it in writing at any time except to the extent action has already been taken in reliance on it, and that information released may be redisclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule.

PATIENT / REPRESENTATIVE SIGNATURE _____ DATE _____

PRINTED NAME _____ RELATIONSHIP TO PATIENT (IF REPRESENTATIVE) _____

When is a signature required? A signature is **not** required when records go directly to another healthcare provider for treatment purposes (45 C.F.R. § 164.506). It **is** required for releases made at the patient's request or for any non-treatment purpose, and for any specially protected information listed in Section 7.

E · RELEASE TRACKING — NOVA MEDICAL GROUP USE

DATE REQUEST RECEIVED _____ REQUEST RECEIVED FROM (PATIENT / FACILITY / OTHER) _____

DATE SENT	RECORDS SENT	METHOD	PAGES	RELEASED BY	CONFIRMED

Method: fax · secure email · mail · secure exchange · portal · hand-delivered. File the confirmation (fax receipt, delivery confirmation, or portal timestamp) in the patient's chart.

5 How to Send These Records

Choose whichever is easier — there is no need to use both.

Option 1 — Email

documents@novamedicalgroup.net

Please include the patient's full name and date of birth in the subject line.

Option 2 — Mail

Nova Medical Group
Attn: Medical Records
401 North Bedford Street
East Bridgewater, MA 02333

Questions? Call our office at (781) 375-3150, or fax records to (781) 375-3146.

6 Records Requested

Please send **only** the records listed below. Time frames are measured from the date of this request. If an item does not exist for this patient, note "none" and continue.

	RECORDS REQUESTED	TIME FRAME / QUANTITY
✓	Office visit records	**Most recent 2 years**
✓	Mammograms / breast imaging (reports, and images if available)	**Most recent 3 years**
✓	Colonoscopy reports and associated pathology	**2 most recent**
✓	Blood work / laboratory results	**Most recent 2 years**
✓	CT scans and MRIs (reports, and images if available)	**All available**
✓	DEXA / bone density scans	**2 most recent**
✓	Cardiac testing (EKG, echocardiogram, stress test, cardiac monitoring)	**All available**
Most recent 2 visits / records with each of the following specialists, if the patient has seen them:		
✓	Cardiology	**2 most recent**
✓	Neurology	**2 most recent**
✓	Hematology / Oncology	**2 most recent**

No other medical records are needed.

Please do ***not*** send the complete or entire medical record. Records outside the categories and time frames listed above are not requested and should not be sent.

Sending only the requested items protects the patient's privacy, reduces copying costs, and helps us review the information more quickly.

7 Specially Protected Information

Certain categories of health information may be subject to additional federal or Massachusetts confidentiality requirements and may require specific or separate authorization. Unless specifically authorized below, this authorization does not independently authorize disclosure of specially protected information where additional authorization is required by applicable law.

- ☐ HIV/AIDS-related information, including HIV testing
- ☐ Genetic testing / genetic information
- ☐ Mental / behavioral health information
- ☐ Psychiatric treatment records
- ☐ Substance use disorder treatment information, where permitted
- ☐ Other:

Psychotherapy notes are not included in this general authorization unless separately and specifically authorized in accordance with applicable law.

PATIENT INITIALS AUTHORIZING THE CATEGORIES SELECTED ABOVE

_____

8 Purpose of Disclosure

☑ **Treatment / continuity and coordination of care** — SELECTED

This is the purpose of every request made on this form.

CHECK ONLY IF AN ADDITIONAL PURPOSE ALSO APPLIES

- ☐ At the request of the patient
- ☐ Transfer of care
- ☐ Other:

9 Patient Authorization

I authorize the healthcare provider or healthcare facility identified above to disclose the medical records and protected health information specified in this authorization to **Nova Medical Group** for the purpose stated above.

1. This authorization is voluntary.
2. I may revoke this authorization at any time by providing written notice to the healthcare provider or organization authorized to disclose the information, except to the extent action has already been taken in reliance on this authorization.
3. My treatment, payment, enrollment in a health plan, or eligibility for benefits generally will not be conditioned upon whether I sign this authorization, except where otherwise permitted by law.
4. Information disclosed pursuant to this authorization may potentially be redisclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule, although other federal or state confidentiality laws may continue to apply.
5. I have the right to receive a copy of this signed authorization.
6. I understand the nature and purpose of this authorization and authorize disclosure of the information identified above.

10 Expiration

☑ **One (1) year from the date of signature** — DEFAULT
Unless revoked earlier in writing by the patient.

CHECK ONLY IF A DIFFERENT EXPIRATION IS REQUIRED

☐ Upon completion of the requested disclosure

☐ Upon the following event:

☐ On the following date:

11 Patient / Representative Signature

PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

IF SIGNED BY AN AUTHORIZED REPRESENTATIVE

REPRESENTATIVE NAME _____ RELATIONSHIP TO PATIENT _____

LEGAL AUTHORITY TO ACT FOR PATIENT _____ REPRESENTATIVE SIGNATURE & DATE _____

Documentation of legal authority may be requested where appropriate.

Provider-to-Provider Record Request

TO THE MEDICAL RECORDS DEPARTMENT / TREATING PROVIDER

1. The above-named individual is currently receiving care from our practice. We request the records identified above for purposes of treatment, continuity of care, and coordination of healthcare. **This is a limited request** — please send only the specific records and time frames identified in Section 6. No other records are needed, and the complete medical record should not be sent.
2. To the extent applicable, this request is made pursuant to the HIPAA Privacy Rule, including 45 C.F.R. § 164.506, which permits disclosure of protected health information by a healthcare provider to another healthcare provider for treatment purposes without requiring the patient's authorization.
3. A signed patient authorization is included above to facilitate processing of this request and to address disclosures for which authorization may be required.
4. Please transmit the requested records using one of the methods listed in Section 5. If you are unable to fulfill this request, require your institution's own authorization form, or need additional information, please contact our office at (781) 375-3150.

☑ For Nova Medical Group Use

REQUESTING PROVIDER

REQUESTED BY

DATE REQUESTED

DATE RECORDS RECEIVED

STAFF INITIALS

FOLLOW-UP DATE (IF NEEDED)

METHOD RECEIVED

Fax Secure electronic exchange Secure email Mail Other

Confidentiality notice: this request and any accompanying information may contain confidential health information protected by federal and state law. It is intended only for the authorized recipient and for the purposes described above. If received in error, please notify the sender and securely destroy or return the information as appropriate.