

RECORDS REQUEST FORM

Please provide records for the following patient:

NAME: [REDACTED]

Date of Birth: [REDACTED] / [REDACTED] / [REDACTED]

Home Phone#: [REDACTED]

*REASON FOR CONSULT: CONTINUITY OF CARE

PLEASE PROVIDE ALL OF THE FOLLOWING RECORDS AVAILABLE:

- MRI studies: Brain, C-Spine, T-Spine, L-Spine

PLEASE SEND APPROPRIATE MEDICAL RECORDS & INSURANCE INFORMATION ASAP
VIA CD AND AMBRA TO:

christine.boster@bosterms.com
or US mail

- Neurology Office Visit Notes
- Urology Office Visit Notes
- Labs (Specialized Testing if applicable)
 - EMG
 - Functional Capacity Exam
 - Neuro Psychometric Testing
 - Lumbar Puncture
- Current Medication List
- Current Vaccine records
- Ophthalmologic Exams / Office Visit Notes
- **Hard Copys of MRI discs**
- Therapy Notes (PT & OT)

PLEASE SEND APPROPRIATE MEDICAL RECORDS & INSURANCE INFORMATION ASAP



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

Specify Provider/Organization Name and Facility Address

Organization Name: _____
Address: _____

Release Records to:

The Boster Center for Multiple Sclerosis
8000 Ravines Edge Court, Suite 200
Columbus, Ohio 43235
Phone: 614.304.3444 Fax: 614.304.3433

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

Patient's Full Name: _____

Maiden or former name: _____

Date of Birth : ____ / ____ / ____ **SSN/Medical Record No.:** _____

Address: _____

Covering the period(s) of health care: ____ / ____ / ____ to ____ / ____ / ____

1 Information authorized for disclosure, if included in my records:

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Visit/Discharge Summary | <input checked="" type="checkbox"/> Progress Reports | <input checked="" type="checkbox"/> Pathology Reports |
| <input checked="" type="checkbox"/> Clinical Documentation of Physical | <input checked="" type="checkbox"/> Radiology/Diagnostic Imaging | <input checked="" type="checkbox"/> Laboratory tests |
| <input checked="" type="checkbox"/> Documentation of Consultation | <input checked="" type="checkbox"/> Reports/MRI discs: Brain, C-Spine, | <input checked="" type="checkbox"/> Neuropsychometric OVN |
| <input checked="" type="checkbox"/> Immunization Records | T-Spine, L-Spine or released to Ambra: | <input checked="" type="checkbox"/> Physical Therapy OVN |
| | christine.boster@bosterms.com | |

2 If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed (please initial below):

- Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- Behavioral Health Services I Psychiatric Care
- Treatment for Alcohol and/or Drug Abuse
- Sexually Transmitted Diseases (STD)
- Genetic Counseling / Testing

Initial

I understand that the information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3 The purpose for which disclosure is authorized: Continuity of Care

CONTINUED ON NEXT PAGE



4 I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

/ / **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here _____), it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5 I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6 This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Full Name of Patient (or Legal Representative, Parent or Legal Guardian)

(Relationship if not Patient)

Signed: Patient (or Legal Representative, Parent or Legal Guardian)

Date Signed