Cardiology Associates of North Mississippi, PA

Regional Office	Main Office	Regional Office	Regional Office
801 Stark Rd	499 Gloster Creek Village, Suite A-2	2459 Fifth Street North	2892 South Lamar
Starkville, MS 3975	P.O. Box 2519	Columbus, MS 39705	Oxford, MS 38655
	Tupelo, MS 38803 or Fax # 662-620-6938		

INSTRUCTIONS FOR MEDICAL RECORD REQUESTS

Requests For Medical Records

Cardiology Associates of North Mississippi copies and bills for their own medical records, following state and federal laws.

Charges For Medical Records

Patients: $6.00
There is no charge for a request for one date of service.

State Disability and Workers' Compensation: as MS law allows. (Patients are encouraged to contact these entities directly when records need to be requested.)

All other requests (third party, insurance companies, and attorneys): 1-20 pages - $20.00; 21 – 80 pages - $1.00 per page; then 50 cents per page after 80 pages.

Cardiology Associates pre-bills for medical records. No records will be copied before payment is received. Pre-bills will be sent to requestor within 7 working days, after receiving a request for medical records, with a legal authorization, signed and dated by the patient within the last 12 months. Payment should not be sent in advance of pre-bill invoice, as advance payments cannot be tracked.

Medical records will be mailed within 7 working days after payment is received. (Federal law allows 30 days to send medical records.) Medical records for all Cardiology Associates of North Mississippi, PA are processed and mailed from the Tupelo office.

Echo, Nuclear & CTA CD's

$25.00 each plus postage
HEART CATHETERIZATION CD'S WILL HAVE TO BE OBTAINED FROM THE HOSPITAL IN WHICH THEY WERE PERFORMED. THE PATIENT WILL NEED TO CONTACT THE HOSPITAL.

No Charge For Medical Records To Treating Physicians

Cardiology Associates does not charge for medical records to be sent to another treating physician of the patient. This means Cardiology Associates must mail or fax the medical records directly to the treating physician. Echo tapes, CD's Nuclear & CTA are sent without charge only when the physician asks for these directly from Cardiology Associates.

Authorization Form

1. Must complete specific information or time frame (requests may be returned if not completed).
2. Must initial "no limitations" section.
3. Sign and date the front sheet.
4. Check one of the boxes at the top of the back sheet
5. Sign and date the back sheet (down 3/4 of the page).
(Note: The bottom signature line on the page is to revoke the authorization ONLY.)

(Revised 01/2015)

CARDIOLOGY ASSOCIATES OF NORTH MISSISSIPPI, PA.

801 Stark Rd.
Starkville, MS 39759

499 Gloster Creek Village, Suite A-2
P.O. Box 2519
Tupelo, Mississippi 38803-2519

2102 Fifth Street North
Moore's Creek Plaza, Suite 3
Columbus, MS 39705

2892 South Lamar
Oxford, MS 38655

Please return medical request to the above P.O. Box, Tupelo, MS location, attention medical records or fax to 662-620-6938.

Authorization To Release Medical Records

PATIENT IDENTIFICATION:

Patient Name:_____ S.S.#_____
Last First Middle Initial

Address: _____ Phone No.:_____
Street (area code)

_____ Date of Birth:_____
City State Zip Code

MEDICAL RECORDS ARE TO BE SENT TO:

Name of Person or Place:_____ Phone No.:_____

Address:_____ Fax Number:_____
Street City State Zip Code

TO BE USED FOR THE PURPOSE OF: _____ Disability _____ Insurance _____ Attorney

_____Personal Use _____ Continued Treatment _____ For Another Physician _____ Other

INFORMATION TO BE RELEASED:
I, the undersigned, hereby authorize and request Cardiology Associates of North Mississippi, P.A. to release information regarding my medical records for the purpose of review and examination and further authorize and request that you provide such copies as requested. The foregoing is scheduled to such limitation indicated below:

MUST BE COMPLETED:

Confined to the following specific information or specific period of records _____

_____

MUST BE INITIALED:

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including the treatment for psychological or psychiatric impairment, drug abuse and/or alcoholism, or Acquired Immunodeficiency Syndrome or test for or infection with Human Immunodeficiency virus.
Patient Must Initial Here For Authentication Of This Response. _____

Signature of patient: _____ Date:_____

If signed by personal representative, state relationship and authority to do so._____

_____

NOTE TO RECIPENTS(S) RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulation prohibit you from making further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

(Revised 8/2006) **PLEASE SEE BACK SIDE OF FORM** CARD 51

Authorization To Release Medical Records
Continued

Check one:

( ) This authorization expires on: _____sixty days from date of signature.

( ) End of research (only if use or disclosure is for research purposes).

( ) None (only if uses or disclosure is for creation and maintenance of research database or research repository).

We will not condition your right to treatment or payment on your granting this requested authorization unless (1) your treatment is research-related and this authorization is for use or disclosure in connection with that research, or (2) the health care you will receive is for the purpose of disclosure to a third party and this authorization relates to its disclosure to that third party.

You have a right to refuse to sign this authorization.

You have a right to inspect or have a copy of the protected health information that will be used or disclosed by us. See our Notice of Privacy Practices for details.

Except to the extent that we have already relied on it, you have a right to revoke this authorization by doing so in writing addressed to the following:

Cardiology Associates of North Mississippi, P.A.
P.O. Box 2519
Tupelo, MS 38803-2519
Attn: Privacy Officer

(Revocation may be denied if your authorization was required in order to obtain an insurance policy and the insurer has a legal right to contest the policy or a claim under the policy.)

The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that require health care providers to protect individually indentifiable health information.

If the use or disclosure for which authorization is being sought is for marketing purposes:
Use of disclosure ( ) will (X) will not result in direct or indirect remuneration to us from someone else.

Patient Signature: _____ Date: _____

Print Patient Name: _____

_____
Authority of Personal Representative, if signing for the Individual.

Provide A Copy To The Individual

CARDIOLOGY ASSOCIATES OF NORTH MISSISSIPPI, P.A.

INDIVIDUAL REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION

I, _____, hereby revoke an authorization dated _____(use approximate date if date of authorization unknown) to use or disclose individually identifiable health information about me except to the extent that action has been taken in reliance on that authorization. If the authorization was obtained as a condition of my obtaining insurance coverage, I understand that this revocation is effective only to the extent that other law provides the insurer with the right to contest a claim under the policy.

Date: _____ Patient Signature: _____ Patient Identifier: _____

Address: _____ Telephone No. : _____