HEALTHMARK GROUP

ST. CLOUD EAR, NOSE & THROAT

Questions? Contact Healthmark Group
at: 800.659.4035
status@healthmark-group.com

ST. CLOUD EAR, NOSE & THROAT CLINIC, P.A.
MEDICAL RECORDS RELEASE AUTHORIZATION

To make our process quicker and easier, we outsource our requests for Medical Records to HealthMark Group. HealthMark Group fulfills all patient requests for personal copies at no charge to the patient. By default, records will be sent to you via email or fax. A hard copy can be mailed by calling HealthMark to specifically request paper copies.

To Request a Copy of Medical Records:
Register for an account at https://requestmanager.healthmark-group.com/register
OR
FAX signed form: 800.833.5935
Email signed form: status@healthmark-group.com

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone: _____ Email: _____

I AUTHORIZE THE RELEASE OF INFORMATION TO

Person/Company: _____ Phone: _____

Address: _____ Fax #: _____

City, ST, Zip Code: _____ Email: _____

DETAILED INFORMATION ON THE RELEASE

Dates of Service (Check One and Complete the Dates of Service if Required)

☐ Please provide a complete copy of my file for all dates of service.

☐ Please provide a complete copy of my file for service from _____ through _____.

Records to be Released (45 CFR § 164.508(c)(1)(i))

☐ Entire Chart	☐ Radiology Reports	☐ Operative Reports
☐ Office Notes	☐ Images (a fee may apply)	☐ Physical Therapy
☐ Consults	☐ Medications	☐ Itemized Billing
☐ Lab Reports	☐ Immunizations	☐ Other: _____

Purpose for Disclosure

☐ Continuing Care	☐ Referring Physician	☐ Legal/Attorney	☐ Other: _____
☐ Transfer of Care	☐ Disability	☐ Insurance	

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization except in certain circumstances, such as for participation in research programs or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, the history, diagnosis and treatment of drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Reason if the patient is unable to sign: _____
(Provide guardianship, executor of the estate, death certificate or power of attorney paperwork with request)

If you have any questions, please log in to Request Manager for status updates or to chat with support. You may also contact HealthMark at 800.659.4035 or email status@healthmark-group.com.