HUGHSTON CLINIC
ORTHOPAEDICS

# Attention TN Patients:

Please Read the following before signing the attached release form.

## Fax Number: 706-494-3042

Hughston Clinic medical records department handles all medical requests corporate wide. For questions about your bill for the records or to check the status of the medical records request, please call Hughston Clinic and asked for the Medical Records department at 706-494-3374 or 1-800-331-2910.

The fees are as follows:

- $5.00 Fee — Non-refundable fee for search, retrieval and other administrative costs at time of request.
- Cost per page fee is based upon state of **Tennessee guidelines** and is due upon delivery of records:
  $20.00 for pages 1 through 5 flat fee
  $0.50 per page for pages 6 and over
- Xray Copies — $20.00 per disk
- Postage — Actual Cost of postage (if applicable)
- Certified Records — $9.70 for each record certified (if applicable)

Please make sure that you are very specific when filling out the request for medical records and please make sure to state exactly what medical records you need.

Thank you for taking the time to read this important message in reference to the medical records that you are requesting.

Please sign and date this form so that the medical records department acknowledges that you (the patient) have read and understand the above information.

_____ _____

Signature of Patient or legal representative Date

HUGHSTON CLINIC
ORTHOPAEDICS

RELEASE OF MEDICAL INFORMATION

Patient Request to inspect and copy Protected Health Information

Patient Name: _____ Chart Number: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security #:_____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

I hereby request a copy of my medical record or other recorded Protected Health Information (PHI) as designated below: Please check all that apply.

- O Office visits _____
- O Physical/Occupational Therapy notes
- O X-ray/MRI reports_____CD X-Rays/MRI($20.00) _____
- O Other: _____

Mail a copy of the records requested to me at the above address or as designated below: If you would like to pick them up please list a phone number we can call you to notify records are ready for pickup.

_____

_____

_____

I agree to pay a **$5.00** fee, a **$20.00** per x-ray disk fee (if applicable), any per page cost for documents, a **$9.70** fee for certifying copies (if applicable) and the cost of mailing the abovementioned records. I agree to pay the total estimated cost for these services prior to mailing.

_____ _____

Signature of Patient or legal representative Date

Fax back to 706-494-3042