CAC0907

DMRS
Diversified Medical Records Services, Inc.

About Diversified
Diversified Medical Records Services is an outside company specializing in managing compliance and correspondence copying for medical facilities nationwide.

The company was founded in 1992, is fully HIPAA compliant, and adheres to all state and federal regulations concerning the release of protected health information (PHI).

Medical Record Fees
The state regulates the rates for copies of medical records and those are updated annually.

Diversified Medical Records Services tries to minimize your costs by offering you electronic options as well as a flat discounted rate.

Have a Question?
If you need further information, please call Diversified Medical Records Customer Service at (800) 359-8520.

Dear Patient:

You recently requested records through our office. There is a fee to process medical records requests. Diversified Medical Records Services processes all requests for copies of medical records.

Your records are available to you with the following options.

Options: <u>Please mark your choice:</u>

- **Option 1**: **Complimentary Pertinent:** Receive your most recent two years of physician reports and diagnostic testing (labs, radiology, etc…). This is what most requesters need. Please provide an email address to receive this for free.
- **Option 2**: **Electronic Downloadable Format:** $9.82 or State rates whichever is less. This is if you would like more than most recent two years of history.
- **Option 3**: **Paper:** $12.14 + $0.02 Per Page + Postage or State rates whichever is less. Records will be mailed.
- **OPTION 2 & 3 REQUIRE A PAYMENT WITH REQUEST**.

*Email Address:

Instructions:

- Circle or Check Mark your preferred option above.
- Complete the enclosed authorization entirely. If any area is left blank, the form becomes legally invalid per federal law. **Best Practices**: Complete the new authorization provided to ensure HIPAA compliance so that your request can be processed without further delay.
- **Make a check or money order payable to DMRS for $9.82/$12.14 and the difference will either be invoiced or refunded for OPTION 2 & 3.**
- Mail your payment, this form, **and** your completed authorization to:

WARING COURT PEDIATRIC & ADULT MEDICAL GROUP
3230 WARING COURT, SUITE J
OCEANSIDE, CA 92056

~$9.82 is used as a cost based fee as governed by **45 CFR § 164.524** calculated using the average cost method.~

HIPAA Compliant Request for Information

1. MY INFORMATION:

Patient Name:		Address:	
Phone:	Fax:	City:	State: Zip:
Email Address:		Date of Birth:	Last 4 SSN#:

2. CUSTODIAN INFO: I hereby give the following entity permission to release my Protected Health Information (PHI):

Name:		Address:	
Phone:	Fax:	City:	State: Zip:

3. INFORMATION REQUESTED: I instruct the above entity to release a copy of the following information (Check One):

____ Comprehensive Care Summary (covering 24 months) ____Entire record

____ Specific records: _____

4. WHERE TO SEND: I am requesting the above designated records be released to the following entity or person:

Name:		Address:	
Phone:	Fax:	City:	State: Zip:

5. FORM & FORMAT OF RECORDS: I request the copies of records be delivered as follows (Check One):

√	Form	Format	Method of Delivery
	Electronic	PDF	*Email the records to:
	Electronic	FAX	Fax the records to the number indicated above
	Electronic	PDF	Download – Email a secure link to:
	Hard Copy	Paper	Mailed to the address indicated above

**Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving your records via email to the address you specify.*

6. REASON FOR DISCLOSURE: I am requesting my PHI to be disclosed for the following purpose: _____

7. SENSITIVE INFORMATION DISCLOSURE: HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information within the dates specified above *are to be released through this authorization* unless otherwise checked below:

DO NOT RELEASE: (Check all that apply) ___ HIV ___Behavioral Health ___ Drug/Alcohol

This authorization is valid for 90 days. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date

Failure to complete all fields on this form may invalidate this request