RECORDS REQUEST FORM

Please provide records for the following patient:

NAME:
Date of Birth:

Home Phone#:
*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: info@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 copies of MRI discs
- Therapy Notes (PT & OT)

PLEASE SEND APPROPRIATE MEDICAL RECORDS & INSURANCE INFORMATION ASAP

THE BOSTER CENTER FOR MULTIPLE SCLEROSIS
8000 Ravines Edge Court | Suite 200 | Columbus, OH 43235
614.304.3444 | FAX 614.304.3433 | BOSTERMS.COM

THE BOSTER CENTER
FOR MULTIPLE SCLEROSIS

NAME_____DOB _____

8000 RAVINES EDGE COURT | SUITE 200 | COLUMBUS, OHIO 43235
PH. 614.304.3444 | FAX 614.304.3433 | INFO@BOSTERMS.COM

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:

- ☒ Visit/Discharge Summary
- ☒ Clinical Documentation of Physical
- ☒ Documentation of Consultation
- ☒ Immunization Records
- ☒ Progress Reports
- ☒ Radiology/Diagnostic Imaging
- ☒ Reports/MRI discs: Brain, C-Spine, T-Spine, L-Spine or released to **Ambra**:
- ☒ Pathology Reports
- ☒ Laboratory tests
- ☒ Neuropsychometric OVN
- ☒ Physical Therapy OVN

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

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FOR MULTIPLE SCLEROSIS

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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*