



Policy: Release of Medical Records

Releasing Records to Another Clinical Practice:

1. Medical record requests must be submitted in writing. The Center City Pediatrics Request for Release of Medical Records form should be completed whenever possible. [Attachment A]
2. The following must be provided prior to release of any records:
 - a. Name of Patient
 - b. Patient DOB
 - c. Name of Requesting individual [Print/Signature]
 - d. Requesting individual's relationship to Patient
 - e. Reason for request
 - f. Individual to and Address where records are to be forwarded
 - g. Payment, when applicable
3. At time of request, or prior to provision of any medical records, proof of identification should be obtained whenever possible i.e. when requests are made in person.
4. Parents with legal guardianship, or other legal guardians may request records for those patients UNDER age 18 only. They do not have the right to records regarding sexual health, alcohol or substance abuse, emotional/psychological issues or in the case of emancipated minors.
5. Individuals age 18 and over may request their own medical records. CCP HIPAA Disclosure of Protected Health Information must be completed by patients over age 18 [See Attachment B]
6. The medical record for a patient is defined by state regulation as all 'clinical information pertaining to the patient which has been accumulated by the physician, either by himself or through his agents. Routine requests for medical records when patients leave the practice should include the following information:
 - a. Progress notes from visits
 - b. Letters from sub specialists, laboratory results, reports of any studies/imaging
7. Although we are obligated in most cases to accommodate medical record requests, release of specific treatment notes or **visit notes** must be approved by the Physician/s involved. Physicians should be particularly careful in these cases to protect adolescent patient confidentiality.

8. *Medical Records requests will be assessed the following fees to offset photocopying and personnel costs:*
 - a. *\$10.00 total for less than 20 pages (instead of 10)*
 - b. *\$20 for more than 20 pages and less than 50 pages*
 - c. *\$30 for charts over 50 pages*

9. The exceptions to this charge include:
 - a. In the case of a MEDICAL EMERGENCY where the patient or guardian is unable to authorize release of medical information or when time does not permit obtaining such a release, needed information will be released so that a sound determination of appropriate emergency treatment may be rendered. The name and professional title of requestor must be documented in the medical record. If in doubt as to authenticity of the caller, call the facility back for proper identification and then release the requested information, only after Physician /office manager approval.
 - b. There shall be NO CHARGE for medical records requested for pediatric patients whom are deceased.
 - c. *Social Security requests will follow customary fees.*

Release of Medical Record Information to Insurance/Lawyers:

1. All record releases for medical information going to attorneys should be directed to the physician for review.
2. Requests are usually completed within 10 working days from the date of the signed release.
3. A HIPAA release of protected information (Attachment B) must be completed prior to the release of any information.
4. Once records are copied, a cover letter is sent (ahead of the record) indicating that the records are ready for pickup. The letter includes the amount owed for the records.

5. Once payment has been received, either in person or by mail, records are sent.

District Attorney Request	\$19.80 flat fee
Social Security [disability]	\$25.09 flat fee
Retrieval Fee [Act 26 2009]*	\$ 19.80 flat fee
Pages 1-20	\$1.33 per page
Pages 21-60	\$.99 per page
Pages 61+	\$.33 per page

6. Fees vary for copying/retrieval costs.

* For a patient request under HIPAA, you may NOT charge the retrieval fee.

Date of Policy Origination: July, 2009

2009 CCP MedicalRecordRelease Policy FINAL.doc

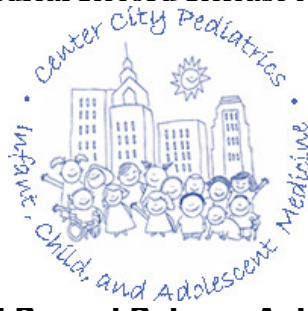
11/18/2009

2 of 6 pages

Revision: Date(s): _____

Signature: _____

Attachment A: Medical Record Release Authorization Form



Medical Record Release Authorization Form

I hereby authorize

Center City Pediatrics, LLC
1740 South Street, Suite 301
Philadelphia, PA 19146
215-735-5600

To release all medical records of my child/children to:

Office/Doctor/Hospital Name: _____

Address: _____

Fax: _____

Child's Full Name _____

Date of Birth: _____

Patient's Address (please indicate all addresses that apply):

Patient Phone: (____) _____

(indicate the phone number that we would be most likely to be able to reach you during work hours i.e. work or cell)

Parent/Guardian Signature*: _____

Date: _____

* You may be required to show a valid driver's license or photo identification when picking up records.

Attachment B- CCP HIPAA Disclosure



**Center City Pediatrics, LLC
Patient Authorization for Use and Disclosure
of Protected Health Information**

By signing this authorization, I authorize Center City Pediatrics, LLC to use and/or disclose certain protected health information (PHI) about me to _____.
Name of entity *receiving* this information

This authorization permits Center City Pediatrics, LLC to use and/or disclosure the following individually identifiable health information (IIHI) about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

- Continuity of medical care
- _____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____.
Expiration Date or Defined Event

I do not have to sign this authorization in order to receive treatment from Center City Pediatrics, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Privacy Officer
Center City Pediatrics, LLC
1740 South Street, Suite 301
Philadelphia, PA 19146

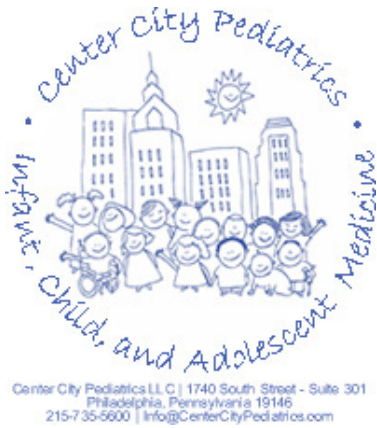
Signed by: _____
Signature of Patient/Legal Guardian Relationship to Patient

Print Name of Patient/Legal Guardian

Patient's Name Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

Attachment C- CCP Sample Invoice



Date

Address

RE: PT Name
DOB
Ref #

Dear _____ :

We are in receipt of your request to provide you with medical records for the above-referenced patient. The cost for providing the information requested is \$_____.

Please forward this amount to my attention at your earliest convenience. The request will be processed upon receipt of payment.

Sincerely,

Center City Pediatrics, LLC
215-735-5600