



Dedham Medical Associates
Granite Medical Group
Harvard Vanguard Medical Associates
PMG Physician Associates

Requesting a Copy of Your Medical Record Information

The Release of Information Department of Atrius Health has trained professionals who manage your health information and medical record.

Frequently asked questions and answers from patients requesting copies of medical records are listed below.

Please note – Our office is not located within a medical practice; therefore, it is not physically accessible to patients.

If you have any additional questions, please contact the Release of Information Department during our normal hours of operation.

Mailing Address:

Release of Information Department
Atrius Health
1177 Providence Hwy
Norwood, MA 02062

Hours of Operation:

Monday – Friday: 8:00AM – 4:00PM

Telephone and Fax numbers:

Tel: 781-292-7700 Fax: 617-421-2626

FREQUENTLY ASKED QUESTIONS

Q. How do I obtain a copy of my medical record?

A. To process your request for copies of medical records, Atrius Health needs either a completed authorization form or a signed letter. Your request should be mailed or faxed to the address above. A copy of our authorization form should accompany this FAQ sheet, and can also be downloaded from our website, www.AtriusHealth.org. If you prefer to write a letter it must include your name, date of birth, phone number, specific information you are authorizing for release, and the person/organization authorized to receive the information along with their address.

- *In most cases patients 18 years or older must sign their own authorization unless a legal guardian has been established by the court.*
 - *Proof of legal authority/representation is required.*

Requests for Billing information, Pharmacy records, and/or Radiology Images/Films must be made directly to each of those departments

Q. Is there a cost to obtain a copy of my medical record?

A. Yes, we reserve the right to charge a reasonable cost-based fee for producing the copies. It is based on the cost allowed by HIPAA (45 CFR, 164.524) or Massachusetts law (MGL Chapter 111; Section 70) whichever is less, plus postage. You will receive an invoice from our copy service, Bactes, shortly after we receive and process your request.

Please note: If you do not need a copy of your *complete* medical record, you may request an "abstract", which contains immunizations, two (2) years of office visit and lab information, and five (5) years of radiology and diagnostic reports. The abstract is often sufficient to meet the need of many requests, including transfer of care to a new provider. Furthermore, you may elect to have your records delivered electronically, which is often times much less expensive and faster than printing and mailing.

Q. How can I submit my payment?

A. You will receive an invoice from our copy service, Bactes, shortly after we receive and process your request. Payment must be received by BACTES prior to the release of your records.

Q. How soon can I expect the release of my medical record to be completed?

A. Processing time varies depending on the type of request and method of delivery. Routine requests are usually prepared within seven business days and released upon receipt of payment. There are instances where a request may take longer to process.

The following scenarios are the most common that require additional time to process

- Requests for copies of Behavioral Health records that are being released directly to the patient take longer because we are required by law to obtain approval from the clinician prior to releasing.
- Requests that contain information under the 'Information Requiring Specific Consent' box of the authorization form that was not initialed for may take longer because the information has to be redacted.
- Older information may be delayed because a hard chart may have to be retrieved from storage.

Authorization to Release Medical Records from Atrius Health

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____
 (Please Print)

Address: _____ Telephone No. _____
 Street City State Zip

RECIPIENT INFORMATION

I hereby authorize Atrius Health to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility:

Recipient/Facility's Name: _____
 (Please Print)

Address: _____ Telephone No. _____
 Street City State Zip

DELIVERY INFORMATION

Please check one:

- Email: _____ CD via USPS to the address noted above
 (Please print your email address clearly)
- Paper copy via USPS to the address noted above

INFORMATION TO BE RELEASED - PLEASE REFER TO THE FREQUENTLY ASKED QUESTIONS (FAQ) SHEET FOR INFORMATION REGARDING FEES -

Please check one:

- Abstract** (Includes immunizations, 2 years of office visits and labs, and 5 years of radiology and diagnostic reports)
- Other** - please be as specific as possible in the space below. Include date range, specialty, providers, etc.: _____

RELEASE OF INFORMATION REQUIRING SPECIFIC CONSENT

The following categories of information may be included in your medical record and **WILL NOT** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

<u>Category</u>	<u>Initials</u>
Abortion	
Alcohol/Drug Abuse	
Behavioral Health	
Domestic Violence	

<u>Category</u>	<u>Initials</u>
Genetic Testing	
HIV/AIDS Results/Treatment	
Rape/Sexual Assault	
Sexually Transmitted Diseases	



**PLEASE CONFIRM THAT YOU
 HAVE INITIALED ALL
 CATEGORIES OF
 INFORMATION THAT YOU
 WOULD LIKE RELEASED**

REVIEW AND SIGNATURE

I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Atrius Health unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required. I may revoke this authorization at any time by submitting a written notice of revocation to Atrius Health at the address listed above. The revocation will be effective upon Atrius Health's receipt of my written notice, except that it will not have any effect on any action already taken by Atrius Health in reliance on this authorization. Once Atrius Health has disclosed my health information to the recipient, Atrius Health cannot guarantee that the recipient will not redisclose my health information to a third party. This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____

 Signature of Patient or Legal Representative

 Date

 Printed Name of Patient or Legal Representative

 Relationship to Patient – *Proof of legal authority may be required*