# Instructions for Obtaining Your Medical Records and Completing the Authorization to Use and Disclose Protected Health Information Form

## I. Instructions for accessing your medical records via your Bookmark Medical Portal Account

- If you are not already registered with the Bookmark Medical Patient Portal (MyBookmark) please visit: bookmarkmedical.com/patient-portal to set up your account.
- Your medical records are available for printing through the portal home page.
  - Click on the HEALTH INFORMATION drop-down on the left-hand side.
  - Click PRINT RECORD and follow the instructions.
- If you are unable to locate specific information via the portal, proceed with completing the ***Authorization to Use and Disclose Protected Health Information Form***, following the instructions below.

## II. Instructions for Completing the Authorization to Use and Disclose Protected Health Information Form

- Please print and complete each section of the form. Be sure to PRINT all entries on the form CLEARLY to avoid any potential delays in processing your request. Additional instructions for completing this form are included below.

### SECTION I: Patient Information

- Please complete all patient information, including any other previous names used.

### SECTION II: I Hereby Authorize Bookmark Medical To

- Clearly specify where you are requesting the records are to be released to or from.

### SECTION III: Purpose of Request

- Be sure to select the appropriate purpose of the request.

### SECTION IV: Information to be Released

- Specify whether you are requesting a 2-year abstract of all your records **OR** complete the information for the other options listed in this section.
- Enter the specific provider's name you are requesting information for or enter "ALL" for all Bookmark providers.

### SECTION V: Delivery Format

- Please select only ONE method of delivery listed in this section.
- Email delivery is the preferred and fastest option to process your request.
- If nothing is selected, electronic copies will be sent via Secure email by default (if you have provided an email address).

### SECTION VI: Restricted Authorization to Release Protected Information

- Sensitive information, as defined by the categories listed on the form, will not be released unless you provide specific authorization by INITIALING in the box to the left of each appropriate category.

### SIGNATURE/ DATE

- The request will not be processed without a valid Patient or Parent/Legally Recognized Representative signature and date**.**

### SUBMITTING FORM

- You can deliver your complete form to your provider's office in-person, by fax, or by mail.
- Please direct all medical request questions to your provider's office.
- If the practice location has closed or moved, please contact Care Finder for assistance at: #1- 800-488-5959.

### FEE INFORMATION:

- For Patients requesting a copy of their medical records, *Pursuant to HIPAA 45 CFR, 164.524,* we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two-year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.

# Authorization to Use and Disclose Protected Health Information

**Practice/Location Name:** _____

**Practice ID#:** _____

BOOKMARK MEDICAL

Patient Name: _____ Previous Names Used: _____

Date of Birth: _____ Phone: _____ Patient Address:_____

City/ State/ Zip: _____ Email: _____

## SECTION II: I Hereby Authorize Bookmark Medical To:

***Please select one:*** ☐ Release copies of the above-named patient to ☐ Obtain medical information from

Recipient Name (*Self or Name/ Facility):* _____

Address: _____ City/State/ Zip: _____

Phone #: _____ Fax #: _____ Email: _____

## SECTION III: Purpose of Request

☐ **Personal** ☐ **Referral or 2nd opinion** ☐ **Legal** ☐ **Insurance** ☐ **Other** _____

☐ **Transfer** (*Transfer reason):* ☐ **Moved/Moving** ☐ **Insurance No Longer Accepted** ☐ **Other** _____

## SECTION IV: Information to be Released

☐ **2 Year Abstract of my records for all of Providers *OR* Check AND Complete Below**

☐ **Office Visits:** Dates From_____ to _____ Provider(s)/ Specialties _____

☐ **Other** *(please specify)* _____

****** Please DO NOT pre-pay. You will be invoiced for your selection by our Vendor ******

## SECTION V: Delivery Format

***Please select ONE from below. If nothing is selected, electronic copies will be sent via Secure email on file***

☐ Email _____ ☐ Fax _____ ☐ Paper (via USPS) ☐ CD (via USPS)

## SECTION VI: Restricted Authorization to Release Protected Information

**IMPORTANT: 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.

**** Please do not skip any items as it could impact our ability to fulfill your request and cause delays. ****

| Initials | Category *(of Information to be released)* | Initials | Category *(of Information to be released)* |
|---|---|---|---|
| | Alcohol and/or Substance Abuse Treatment *** | | HIV/ AIDS Screening Test Results/ Treatment |
| | Child/Elder Abuse or Neglect & Abuse of Disabled Adult | | Mental/ Behavior Health or Disability Services * |
| | Confidential Communications w/ a Social Worker | | Rape/ Sexual Assault victim Counseling |
| | Domestic Violence Victim Counseling | | Sexually Transmitted Disease (STD) |
| | Genetic Testing/ Test Results ** | | Other *(specify)*: |

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.

*** Only applicable records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here Date Here

**Signature of Patient or Parent/Legally Recognized Representative** **Date**

**Term:** This Authorization will remain in effect until Bookmark Medical fulfills this request.

**Revocation:** I understand that I may revoke this Authorization at any time by requesting it of Bookmark Medical in writing with the provider's practice. The revocation will be effective immediately upon Bookmark Medical's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Bookmark Medical in reliance on this Authorization before it received my written notice of revocation.

**Effect on Treatment:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, or quality of my treatment at Bookmark Medical.

**Potential for Redisclosure:** I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Bookmark Medical.

**Access**: I understand that in certain circumstances Bookmark Medical has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.

**Please deliver your completed form to your provider's office in-person, by fax, or by mail. If the practice location has closed or moved, for assistance please call #1- 800-488-5959. (REV. 09/26)**