Natural Health Center, LLC
compassionate care changing lives

3330 EAGLE STREET ANCHORAGE, AK 99503
T (907) 561-2330 F (907) 561-1282

REQUESTING YOUR MEDICAL RECORDS

Natural Health Center, LLC follows the HIPAA Privacy Standards (April 14, 2001) to safeguard your health information and give you more control over its use and distribution. This standard enables you to:

- find out what disclosures of your medical information have been made

- request a copy of your own health record and request corrections

- and generally limits release of your information to the minimum needed for the purpose of the disclosure.

At NHC, we most often receive requests to and from other medical providers involved in a patient's care, from legal professionals and insurance companies involved in personal injury cases, from insurance companies and other agencies evaluating certain policies and/or benefits, and from our patients who want a copy of their records for personal use.

We comply with all of these requests with the proper authorization. Any request for medical records, regardless of where it originates, must be accompanied by a written AUTHORIZATION TO DISCLOSE HEALTH INFORMATION. NHC's form may be found on this website. You may use ours, **or** an authorization from the entity on the other end of the request. NHC's form has TO and FROM sections allowing the clinic to receive patient records from another provider into our clinic, **and** to send records out to a doctor, lawyer, insurance company, patient… Each and every request requires your written permission to proceed.

Each request for medical records coming into NHC, is FAXED to the provider we need records from and filed until that information is received. Then it goes in your chart so you and your health care provider here can review it. Requests for medical information going out are passed along to the Medical Records Custodian who logs and processes them. Records requested for other medical professionals are provided at no charge as a professional courtesy. Likewise, we will provide you with one personal copy of your records per year at no charge. There will be a copying fee for multiple requests for the same records made within a year. For records going out to other entities (lawyers, insurance companies, government agencies…) we generally require pre-payment of records fees.

The time required for records to come into NHC varies depending upon the processing speed at the other end of the request. However, you may help us greatly by providing specific contact information about the doctor/clinic/hospital disclosing your records. Listing “Dr. Johnson,” with no phone number, clinic name, or city requires sleuthing on our part – delaying your records request. They may be returned to you for more information, slowing the process further.

The Medical Records Custodian requires a minimum of 10 business days to process an out-going request. This time frame is impacted by the speed at which records fees are paid, and the availability of your NHC provider to review the request. After payment and review, your records are either FAXED or priority mailed to the receiving entity specified on the AUTHORIZATION TO DISCLOSE HEALTH INFORMATION.

Patients should be aware that NHC will release records only from health care professionals currently working in our clinic. This means that you must authorize a separate request to providers no longer at NHC, or to those who have offered you care in conjunction with your NHC provider, for example; records from a medical specialist, test results from an imaging center not ordered by our providers, case notes from a social service agency… Also, billing departments and billing agencies are not required to obtain this level of authorization from you. As a patient, you provide them with legal authorization when you sign the NHC Intake Form. This allows the minimum exchange of information necessary to process payment and benefits on your account.

The above standards and requirements apply to persons for whom you are a legal representative; such as a parent or legal custodian. Listing a person as someone with whom NHC may discuss your medical information (on our green Patient Consent and Acknowledgement Form) <u>does not</u> specify them as a legal agent who can authorize requests for medical records on your behalf.

You may ask questions, review your records, and change consent/authorization forms by contacting us at the clinic. Our patients’ rights and privacy are supremely important to us, and are respected and protected at all levels within NHC.

The Medical Records Request form begins on the next page.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize use or disclosure of my protected health information as described below:

PATIENT NAME____ DATE: _______________

DAY PHONE: _________________________BIRTHDATE: _________________SS#_______________________

APPROXIMATE DATE OF TREATMENT: FROM_____________ TO: ________________
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:

NAME OF DOCTOR OR HOSPITAL

ADDRESS

CITY STATE ZIP

PLEASE CHECK OFF THE ITEMS REQUESTED:

_ **All clinic records only (no lab reports, no x-rays)**
_ **X-Ray film copies**
_ **All dates**
_ **Only these specific dates are needed___________________ to __________________**
_ **Lab Results**
_ **Other**

This information is being sent for the purpose of:

_ At request of the individual
_ Please fax my records to: ______________________________ Fax #: ____________________________
_ Please mail my records at the address listed below:

This information may be disclosed to and used by the following individual or organization:

NAME OF DOCTOR OR HOSPITAL

ADDRESS

CITY STATE ZIP

A. I understand that under HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment.
B. I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

____ ____
Signature of Patient/Legal Representative Expiration Date of Authorization
(Not more than six months after date the authorization was signed.)

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Relationship if other than patient