

Patient Instructions for Medical Record Requests

Towson Sports Medicine has partnered with HealthMark Group to ensure the accurate and timely completion of medical record requests.

How?

Requests may be submitted electronically to HealthMark's Request Manager at <https://requestmanager.healthmark-group.com>. Once logged in, select "Submit Request" from the menu options and enter all required fields to provide an authorization directly to HealthMark. Your medical record request will be processed and a notification will be sent via mail or email once complete and available for download.

Any questions?

Please log in to Request Manager for status updates or to chat with support. If you have any questions, you may contact HealthMark at 800-659-4035 or status@healthmark-group.com.

Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to:

To Recipient:

Person/Company

Address

City

State

Zip

Phone

Fax

From Clinic/Hospital:

Patient:

Patient Name

Phone

Date of Birth

(Email address)

Dates of Service (Check One and Complete Dates of Service if Required)

Please provide a complete copy of my file for all dates of service

Please provide a complete copy of my file for service from _____ through _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

- | | | |
|--|--|--|
| <input type="radio"/> All Medical Records (no films) | <input type="radio"/> History & Physical | <input type="radio"/> Consultation Reports |
| <input type="radio"/> Emergency Room Record | <input type="radio"/> Operative Report | <input type="radio"/> Discharge Summary |
| <input type="radio"/> Lab/Pathology Reports | <input type="radio"/> Radiology Reports | <input type="radio"/> Images (check for CD of films) |
| <input type="radio"/> Itemized Billing | <input type="radio"/> Other _____ | |

Purpose for Disclosure

- | | | |
|---|---------------------------------------|---|
| <input type="radio"/> Disability | <input type="radio"/> Insurance | <input type="radio"/> Attorney |
| <input type="radio"/> Referring Physician | <input type="radio"/> Patient Request | <input type="radio"/> Other (please state reason) |

Other _____

Please indicate your acceptance by checking the following boxes:

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative