PINEHURST SURGICAL

excellence in practice

Dear Requestor:

Recently, you requested a copy of your medical information. We cannot release the original copy, but would be happy to provide a duplicate copy of the information contained in your medical record. In order to do so, the following list will apply while processing your request:

- Completed Records Release From (Must be signed, dated and completed.)
- Completed records must be picked up within 45 days.
- Any records older than 45 days will be destroyed and any future requests will need to be paid in advance prior to processing the request.
- A picture ID will be required to pick up any records.
- Payment in full must be paid prior to releasing the records.
- Any records that are requested the same day will be charged a stat fee of $5.00 plus all other applicable fees.
- It will take between 10-14 BUSINESS DAYS to complete your request.

Also, please understand that the cost of staff, mailing fees and supplies to copy medical information requires that we charge a fee to cover the expenses to duplicate this information. Please review the following fees as payment for these services is due upon receipt of the medical record. The average cost for copying medical records for a patient is $15.00. Should you have any questions, please send us your specific questions or concerns via a fax (910) 295-7944 or by e-mail to RequestInformation@pinehurstsurgical.com. If e-mailing, please be sure to enter the Patient Name and your request date in the subject field of the e-mail.

Do not contact our Health Information Department by phone. Due to our heavy volume of request, we can no longer return phone calls. Please use either fax or e-mail to contact us with your questions.

We thank you in advance for your cooperation.

Sincerely,

Mary T. Fedele, MS
Director of Reimbursement

Request Fees

Insurance	$20.00 Retrieval Fee $18.00 Base Fee $1.25 per page
Permanent Transfer (Moving or transferring treatment)	$10.00 for pages 1-20 if over 20 pages or large volume chart charge $.50/page
2nd Opinion	$10.00 for pages 1-20 if over 20 pages or large volume chart charge $.50/page
Primary Care Physician Follow-up Tx.	Courtesy (Mailed to Primary Care Physician)
Self	$10.00 for pages 1-20 if over 20 pages or large volume chart charge $.50/page
Vocational Rehab	$12.00 (Regulated by statutes of NC)
VA Affairs	No Charge

Medical Record Release of Records

Patient Name: _____ Date of Birth: _____

SS#: _____

Address: _____

_____

Patient's Medical Record Number: _____ Phone #: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

I, _____ do hereby authorize Pinehurst Surgical Clinic to release the following information:

☐ Lab & X-Ray Reports ☐ MRI Results ☐ Clinic Notes ☐ OP Reports

☐ H&P ☐ D/C Summary ☐ Emergency Report ☐ Pathology Report

☐ Entire Chart _____ DR: _____ Other: _____

☐ X-Ray Films ☐ CT Scans ☐ MRI Films

I do ☐ I do not ☐ authorize release of information related to AIDS or HIV Infection, sexually transmitted diseases, psychiatric care and or psychological assessment, and treatment for alcohol and/or drug abuse.

Release Information to : _____

Name of Company/Agency/Facility/Person

_____

Street Address

_____

City, State and Zip

Authorized Private Health Information will be used and disclosed for the following purposes.

_____

- I have received a copy of the Pinehurst Surgical Clinic's Notice of Privacy Practice
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I also understand my signature will be required prior to my request being completed.
- Pinehurst Surgical Clinic may use or disclose such protected health information only until expiration date or expiration event relating to the individual or purpose of the use or disclosure.
- At all times, I retain the right to revoke this Authorization. Such revocation must be submitted in writing to Pinehurst Surgical Clinic Attn: Medical Records PO Box 2000 Pinehurst, NC 28374.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the federal or state confidentiality rules.
- This Authorization will automatically expire six months from the date signed.
- I understand that I may be required to pay a fee for copying these medical records.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Phone Number: 910-215-2503 Fax Number: 910-295-7944

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