REMOTE AREA MEDICAL®

Medical Records Request

Remote Area Medical® •2200 Stock Creek Boulevard • Rockford, TN 37853
Phone: (865) 579-1530 •Fax: (865) 609-1876

Remote Area Medical® processes medical records requests ***at no cost*** to individuals, agencies, medical offices, or other legally authorized entities. To release medical information we must receive the following:

- A valid, signed medical records release that has been hand-delivered, mailed, or faxed.
- Date(s) and location(s) of medical services received at a RAM® clinic (**below**)
- An initialed statement regarding the release of records for specified treatments and/or diagnoses , including sensitive information regarding the diagnosis and/or treatment of psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS or HIV status) (**See Page 2**)

Please complete and return this page in order to facilitate completion of the medical records request sent on _____ /_____ /_____
Day Month Year

Please direct any questions regarding this request to the address, phone number and fax listed above.

Patient Name: _____ **Date of Birth**: ____ /____ /____
Day Month Year

Date(s) and Location(s) of Service
In order to fulfill a medical records request for treatment provided at a RAM® clinic we require a list of ***all dates (at least the month and the year)*** and ***all locations*** (at least the city or county ***and*** the state) for which you are seeking medical records for a patient treated at a RAM® clinic(s):

Year: 2014	Month: October	**Day: (23-26)** _____	Location: Seattle, WA
Year: 2014	Month: October	**Day: (23-26)** _____	Location: Seattle, WA
Year: 2014	Month: October	**Day: (23-26)** _____	Location: Seattle, WA
Year: 2014	Month: October	**Day: (23-26)** _____	Location: Seattle, WA

Remote Area Medical® is authorized to release medical information to:

Agency/Representative: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email address: _____

Signature of Patient/Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

BOTH SIDES OF THE FORM MUST BE *SIGNED* AND *COMPLETED*,
THEN FAXED TO (865) 609-1876 OR MAILED TO 2200 Stock Creek Boulevard • Rockford, TN 37853

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Authorization for Release of Medical Records

RAM® will provide all medical records we have on file according to the information received for retrieval purposes. Please note that this information may include sensitive information regarding the diagnosis and/or treatment of psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS or HIV status). By initialing one of the statements below I make known my wishes regarding the release of any information about such diagnosis or treatment.

PLEASE INITIAL THE STATEMENT BELOW THAT APPLIES TO YOUR REQUEST:
(You must initial one choice for your request to be completed)

I DO _____ I DO NOT _____ authorize this information to be released.

I would like to limit the information released to: _____

_____

I understand and agree with the following statements regarding this request:

- I may refuse to sign this authorization; without this authorization, my medical records will not be released
- I may revoke this authorization at any time, excepting actions already taken to fulfill the request
- I understand that this authorization will expire upon the completion of this request; additional requests will require separate authorization
- I understand that information released to any person(s) not affiliated with a health care provider or health plan may not be protected under federal privacy rules and may be shared with others
- I understand that I will receive a copy of this document after completing it

Signature of Patient/Legal Representative: _____ Date: _____

Relationship to Patient: _____

BOTH SIDES OF THE FORM MUST BE *SIGNED* AND *COMPLETED*,
THEN FAXED TO (865) 609-1876 OR MAILED TO 2200 Stock Creek Boulevard • Rockford, TN 37853