.L.O. EYE CARE

POLICY FOR THE RELEASE OF MEDICAL INFORMATION

(Developed in accordance with the P.A. 47 of 2004, The Michigan Medical Records Act)

Fees

- ◊ There will be a $6.50 flat fee for each medical record request.
- ◊ Any postage or shipping cost incurred in providing copies or telephone costs in providing facsimiles.
- ◊ The actual cost of retrieving records seven years or older and those not accessible on-site. Applicable fees may be requested to be paid in advance of providing the requested information.
- ◊ Medically indigent patients may receive one copy of their medical record without charge.
- ◊ These fees do not apply to record copies for the following:
  - Third party payers.
  - Crippled Children Organization.
  - Commission for the Blind.
  - Local Schools
  - When L.O. Eye Care is sharing care with a referral source or for a primary care physician.
  - The charge may be waived for patients who receive intermittent care outside of the community, e.g. a patient spending the winter in Florida. Pertinent pages of the medical record may be forwarded without charge.

Access to Medical Information:

All requests for records must have a signed release by the patient, either the LOPC form, another office's request form (doctor's office, insurance company, disability determination, school, etc.) or a written letter by the patient. The letter must be signed and dated by the patient. All requests must specify to whom the records are to be delivered to and what specific records are to be released. If the patient would like to fill out one of our forms, we can either mail or fax the release or the patient may fill one out in person. The release is also available on our website loeye.com (see HIPAA release link). **Verbal requests cannot be taken** to release records whether they are provided in person or over the telephone. Patients must complete a release form.

The only time a patient does not need to sign a release form is when his or her primary care physician or a physician who has referred the patient to L.O. Eye Care is requesting information. There will not be a charge in these circumstances. The doctor's name must be documented in the chart before forwarding the information. If the doctor's name is not documented, we would need a signed release by the patient.

If the patient is **under** 18 years of age, the patient's legal guardians must sign for the records request. If the patient is 18 years of age, the parents do not have rights to the records. The patient must sign for them.

Family members **are not** able to sign for patient's records, e.g. a husband cannot sign for wife's medical records. Other individuals may sign a release for an adult patient only if he or she has been authorized to act on behalf of the patient through a Power of Attorney. A copy of the documentation appointing the representative must be presented along with the signed release. A copy of the documentation will be kept in the patient's chart.

MR# (Office use only) _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name_____Birthdate _____

Information to be released from: (COMPLETE NAME & ADDRESS) _____

_____

Information to be released to: (COMPLETE NAME AND ADDRESS) _____

_____

Specific information to be disclosed (include dates of treatment):_____

_____

Purpose and need for such disclosure: _____

_____

☐ Information to be sent to patient via email. I understand that email cannot be guaranteed to be secure.

Email address: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to L.O. Eye Care, P.C., 2001 Coolidge Road, East Lansing, MI 48823, Attn: Medical Records. This authorization will automatically expire six months from date of signature. **I understand there may be a charge for my records per the L.O. Eye Care Policy for Release of Medical Records and I will be responsible for these fees.**

I understand that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the federal Privacy Standards.

I have read the above and acknowledge that I fully understand the terms and conditions of this authorization.

Patient Signature:_____**Date:** _____

If the patient is unable to sign or is a minor, complete the following:

_____ _____ _____

Parent/Responsible relative/Legal Guardian **Relationship** **Date**

_____ _____

Witness **Date**

Coolidge Rd., East Lansing:
2001 Coolidge Rd., East Lansing, MI 48823
P: 517.337.1668 F: 517.337.1779

Lake Lansing Rd., East Lansing:
702 W. Lake Lansing Rd., East Lansing, MI
48823 P: 517.332.6523 F: 517.332.3365

Charlotte:
124 S. Cochran, Charlotte, MI 48813
P: 517.543.9899 F:517.543.8418

Fowlerville:
136 E. Grand River Ave., P.O. 618, Fowlerville, MI 48849
P: 517.223.9988 F: 517.223.9071

Howell:
2790 W. Grand Rive Ave., Ste 200, Howell, MI 48843
P: 517.548.3571 F:517.545.2543

Okemos:
5100 Marsh Drive, Okemos, MI 48864
P: 517-349-0150 F: 517-349-0157

Grand Ledge:
1005 Charlevoix Dr., Ste 200, Grand Ledge, MI 48837
P: 517.627.3030 F: 517.627.8088

Lakewood:
1170 Jordan Lake St., Lake Odessa, MI 48849
P: 616.374.3284 F: 616.374.2020

Sparrow Professional Bld.:
1200 E. Michigan Ave., Ste. 110, Lansing, MI 48912 P: 517.374.1040 F: 517.374.1098

Williamston:
425 W. Grand River Ave., Williamston, MI 48895
P: 517.655.2037 F:517.655.1983

Mt. Pleasant:
1535 East Broomfield, Mt. Pleasant, MI 48858
P: 989.772.3339 F:989.772.4846