MEDICAL RECORDS RELEASE

POLICY:

Is the policy of: Optimal Family Care LLC to appropriately, efficiently and a timely manner process a medical records release for a patient requesting his/her records.

PROCEDURE:

1) The patient will be asked to sign a medical release form.
2) The request with the medical records release form will be given to the Medical Director or designee person for appropriate verification.
3) Copies of all the films and reports will then be made and given to the patient.
4) Verify the person receiving the medical records is the patient or the authorized parent or guardian.
5) Records will be keep at the office for 7 years after the date of the last encounter.
6) Optimal Family Care LLC will maintain a secure adequate facility for all active and inactive records.
7) If the center closes it doors, it must notify its patients of such closure. Patient should be notified in such termination, sale, change of ownership or relocation and unavailability to operate where the records were located.
8) In case of a final closing the patients should be notified via telephone calls.

RECORDS RELEASE AUTHORIZATION/ AUTORIZACION PARA LIBERAR MIS RECORDS MEDICOS.

I, ______________________________ hereby authorize

______________________________ to release to:

Optimal Family Care LLC ______________________________ the complete history

records in your possession, concerning my illness and/or treatment during the period:

From: ______________ to: ______________

____

Yo, ______________________________ autorizo

______________________________ a revelar a:

______________________________ mi historia medica en su

posesion relacionado a mi enfermedad y/o tratamiento durante el periodo:

Desde: ______________ hasta: ______________

Patient's Name/: ______________________________ D.O.B. ______/______/______

Nombre

Fecha de nacimiento

Address/Direccion: ______________________________

Mother's Name/Nombre de la Madre:

____

Father's Name/Nombre del Padre:

____

Social Security: ______________________________

X______________________________
Patient/Guardian Signature
Firma del Paciente/ Guardian

X______________________________
Date/Fecha