MIDLANDS ORTHOPAEDICS, P.A
RELEASE OF MEDICAL INFORMATION PROTOCOL

Complete the Authorization for Release of Medical Information form in its entirety.

Mail the completed form to: Or fax to: 803.933.6346

Midlands Orthopaedics, P.A.
Release of Information
1910 Blanding Street
Columbia, SC 29201

The form may also be dropped off at any of our locations.

Allow up to ten business days for the request to be processed.

In accordance with South Carolina Statute 44-115-80, you will be billed for the reproduction of your medical records as outlined below:

$.65 per page for pages 1-30
$.50 per page for all other pages
Clerical fee not to exceed $15.00
Actual postage cost

Any questions concerning the status of your request should be submitted using one of the following methods:

1. Patients may send a secure message by logging into the Patient Portal via our website, *www.midlandsortho.com*. Click on the Patient Portal link. Log-in. Click "Send a message" to submit a question.

2. Call 803-256-4107 (ext.6215) to leave a message for the Records Release team.

BILLING QUESTIONS
Although Midlands Orthopaedics' employees will process your Records Request, we utilize a third party company to deliver and bill for these requests. You will receive a statement from RecordQuest, and you should remit your payment directly to them.

Payment address: RecordQuest, PO Box 2017, Mt Pleasant, SC 29465-2017
If you have a question about your Records statement, you should contact RecordQuest directly. (Phone) 888-300-7410 (Email message via website) www.recordquest.com/contactus.aspx

MIDLANDS ORTHOPAEDICS, P. A. (MOPA)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient's Full Name

Birth Date (Mo/Day/Yr)

Street Address

Social Security Number

City, State, Zip Code

Phone (Home)

At the request of the individual, I _____, do hereby authorize MOPA to release:
(Patient's Name)

DATES OF SERVICE: _____

__DISCHARGE SUMMARY
__HISTORY & PHYSICAL
__PROGRESS NOTES
__OPERATIVE NOTES
__PATHOLOGY REPORTS
__LABORATORY REPORTS
__RADIOLOGY REPORTS
__ECG/EEG/CARIAC CATH
__EMERGENCY REPORTS
__OTHER _____

__I do __I do not authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE RECORDS TO: _____
Name of Company/Agency/Facility/Person

Street Address

Phone :

Fax:

City, State, Zip Code

Email address:

PURPOSE OF DISCLOSURE:

__REFERRAL TO SPECIALIST
__DISABILITY DETERMINATION
__INSURANCE
__PERSONAL
__WORKERS COMP
__CONTINUING CARE
__CHANGE OF DOCTOR
__LEGAL INVESTIGATION

OTHER (SPECIFY): _____

Please provide a current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual or Guardian or
Personal Representative of patient's estate

Date