

Neurology Center of Fairfax

3020 Hamaker Court, Suite 400

Fairfax VA 22031

If You Need Copies of Medical Records...

NCF is very sensitive to patient needs for copies of their medical records. The State of Virginia regulates the response times and fees to patients for copying records. The federal government regulates privacy concerns involved in copying.

NCF has contracted with HealthPort Technologies (HP) to provide copies of medical records for you. If you need copies of medical records, please follow these steps.

1. Authorization form: The law requires patients to authorize copying in writing by specifying what is to be sent and the recipient. Your authorization is good for one year.

Please complete the form provided with this information sheet. By law you may not request copies of the records of another adult, even a family member, unless you have a proper medical power of attorney. We accept faxed authorization forms at 703-876-0258. Blank forms are also available at www.neurologycenteroffairfax.com

Please specify the records you need, based on the choices on the authorization. If you are sending records to another doctor, HP already knows what to send.

2. Costs: Virginia law defines fees that are charged to you, based on the number of pages to be copied. **You pay these costs in advance directly to HP.** There are multiple ways to pay these charges, as noted on the invoice you receive from HP. Copying fees apply in all cases except the following: (1) if an NCF physician refers you to another doctor and (2) if another doctor sends a proper request that you have authorized. (The last two office visits and the most recent test results will be sent at no charge.) Fees apply to all requests for full copies of records.

Please remember that copying fees are payable to HealthPort in advance. HealthPort will send you an invoice. (You can also speed up the process by prepaying your fees with a credit card when you call 800-367-1500. The best day to call customer service is the Friday or Monday following your request.)

Fees are: 50 cents per page for the first 50 pages, 25 cents a page thereafter, plus first class postage when records are mailed. The costs are defined in Code of VA. Ann. 8.01-413.

3. Response Times: Virginia law provides two weeks to respond to copying requests. Most requests are fulfilled in less time, once the fees are paid. Please do not expect the copying to be done while you wait, except in a medical emergency. Longer response times occur when the records you request are in long term storage.

4. Service: Call HealthPort customer service at 800-367-1500 if you have any questions or problems. The site number for Fairfax office patients is 22290. The site number for Reston office patients is 22291.

NEUROLOGY CENTER OF FAIRFAX 3020 Hamaker Court, Suite 400, Fairfax, VA 22031
1830 Town Center Parkway, Suite 305, Reston VA 20190
Phone 703-876-0800, ext. 5004

This request may be faxed to the Neurology Center at 703-876-0258

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patient full name)

NCF Patient Number

(Street address)

Birth date (Mo/Day/Yr)

(City, state, zip code)

Phone (Home)

(Parent/Guardian if Patient < 18 yrs)

Social Security Number

At the request of the individual, I _____, do hereby authorize **Neurology Center** to release:
(Patient Name)

SPECIFIC SERVICE DATES REQUESTED _____

____ SURGICAL REPORTS ____ ENTIRE CHART ____ OFFICE NOTES ____ LAB REPORTS
____ RADIOLOGY REPORTS ____ TESTING (BE SPECIFIC) _____
____ OTHER _____

____ **I do** ____ **I do NOT** authorize 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.

INFORMATION
RELEASED TO: _____

Name of Company/Agency/Facility/Person

Recipient's Entire Address: _____

PURPOSE OF DISCLOSURE:

____ INSURANCE ____ WORKERS COMP ____ LEAVING PRACTICE ____ PERSONAL ____ RELOCATION/MOVING ____ LITIGATION
____ DISABILITY DETERMINATION OTHER SPECIFY: _____

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

I hereby authorize disclose 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 authorization is furnished may not condition its treatment of me whether or not I sign the authorization. **I understand that I will be charged fees for this service.**

NOTE: Virginia Law specifies charges for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia Rates are pgs 1-50 at \$0.50 per pg, pgs 51+ at \$0.25 per pg. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.

Signature of individual or guardian or estate Personal Representative

Date

(If you are not the patient, and the patient is an adult, you must attach a copy of your Power of Attorney.)

Call Health Port for questions at 1-800-367-1500

MEDICAL INFORMATION RELEASED BY HEATHPORT