MIDWEST PHYSICIANS COPY SOLUTIONS

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1. This form, when signed, will authorize Midwest Physicians Copy Solutions, Transfer Chart to disclose specified protected health/billing information about the person named below.

2. Patient Name:_____Date of Birth:_____

3. Records requested from(Doctor,Clinic,Hospital name):_____

4. Date(s) of service to be included:_____

5. Records requested:_____
Provide specific records (for example, Left Hip) **or circle** the following: **ALL**

6. Who are these records being shared with?**(Circle one) Doctor. Lawyer.**
Self. Name:_____
Address:_____
Phone #:_____Fax #:_____
Email address_____

7. How would you like these records sent?**(Circle one) Mail. Email. Fax.**

8. I acknowledge the following statements:
*I understand that Midwest Physicians Copy Solutions, (DBA) Transfer Chart, will charge patients/lawyers (all establishments other than continuing care doctors/clinics/medical professionals) a **CHARGE FOR THIS COPYING SERVICE.** Price is based on the Missouri Department of Health and Senior Services fee schedule.
* I understand that if I revoke this authorization it must be done in writing.
* Unless otherwise revoked this authorization will expire 60 days from the date signed.
*If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
*I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient because it may no longer be protected by federal privacy regulations.
***This authorization is voluntary, and I may refuse to sign this authorization.**

9. Signature:_____ Date:_____

Patients representative (print):_____Relationship:_____
Patient's representative must have legal documentation that authorizes them to act on the patient's behalf.