Dear Patient Requestor:

DataFile Technologies has been contracted by the physician, physician practice, hospital or other entity from which you are requesting medical records to provide Release of Information services you are requesting. DataFile Technologies complies with all Federal and State PHI and HIPAA regulations. We reserve the right to charge the fee schedule for the copying and processing of medical records as set by the State where medical services were received. You will receive an invoice from DataFile Technologies, LLC, with all of the necessary directions to receive your medical records. By signing the Medical Record Release of Authorization you are agreeing to pay DataFile Technologies for these medical records.

- **What do I do first?**
  - Completely fill out the Medical Record Release Authorization. It is very important that you fill in *all* fields pertaining to where you want the information sent. Make sure that you sign and date it.
- **How do I get the signed form back to you?**
  - You may fax it to us at 816-221-4799.
  - You may email it to us at status@datafiletechnologies.com
  - You may mail it to us at: DataFile Technologies, P. O. Box 722, Shawnee Mission, KS 66201-0722
- **How much will it cost for the records?**
  - Once we receive the signed Medical Record Release Authorization we will calculate how many pages are in the record you are requesting. You will receive a pre-payment invoice via email, fax or mail. The invoice amount is calculated based on the state fee structure for the copying and processing of medical records as outlined by the state where medical service was received.
- **How do I get my payment to you?**
  - The fastest way is to make a credit card payment by going to our Website at www.datafiletechnologies.com and clicking “Medical Records Online Payment” in upper right corner.
  - Or, you may write a check and mail it to: PLEASE INCLUDE THE INVOICE NUMBER ON YOUR CHECK!
    - DataFile Technologies, LLC
    - P. O. Box 722
    - Shawnee Mission, KS 66201-0722.
- **How long will it take?**
  - Once your payment is received, we will process and distribute your records within two business days. They will be sent via fax, mail or electronically (if applicable.)
- **What if I have further questions?**
  - Please contact DataFile Technologies by phone at 816-437-9134 or email us at status@datafiletechnoliges.com

We look forward to serving you!

With regards,
DataFile Technologies

DataFile Technologies, LLC
Phone: 816-437-9134
Fax: 816-221-4799
www.datafiletechnologies.com

Medical Record Release Authorization

Patient Name______________________________________Maiden Name________________SS#_____________

Date of Birth________________________Home Phone____________________Cell/Work__________________

Address____City/State/Zip______________________________

Email:____

To send information to:

Name____

Address____

City/State/Zip______________________________

Phone#________________Fax#________________

I hereby Authorize: (Insert the information on the service providing physician/practice that you want records **from**.)

Doctor Name________________________________

Practice Name________________________________

Date Range__________________to____________________

OR

- ☐ 2 Years Entire Chart
- ☐ 5 Years Entire Chart
- ☐ Entire Chart
- ☐ Other______________________
  (Be Specific Please)

For the purpose of :_______________________________________

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I gave my specific authorization for these records to be released. I hereby release any one, or all of you collectively, from any and all legal responsibility that may arise from the above act authorized by me.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information , I can contact the authorized individual or organization making disclosure.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

__________________________ (Date)

____**(Please Read the info below)**
(Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date: ____________________________
(Expiration date of authorization)

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