HIPAA RELEASE FORM

The attached "Request for Access to Protected Health Informtion" should be completed and returned to Magnus Health Portal. Magnus Health Portal will be able to submit requests on your behalf to all healthcare providers who have cared for you during the past ten (10) year period. Healthcare providers include not only physicians and other individuals who have provided care to you, but also hospitals, ambulatory surgery centers and other facilities where you have received care.

This form complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In most cases this HIPAA release will be sufficient; however, some healthcare providers have developed their own authorization form and may require that you complete their form rather than accept the attached form. In that case, Magnus Health Portal will notify you.

In accordance with HIPAA, healthcare providers may require you to pay a reasonable fee for copies of your medical records in order to cover administrative costs. In this case, the healthcare provider will contact and bill Magnus Health Portal. Magnus Health Portal will pay the fee up front and then bill you. This form allows you to agree for providers to charge you up to $15. You can also choose to not accept any charges. If the cost will be in excess of $15, the provider will contact Magnus Health Portal and Magnus Health Portal will contact you for authorization to pay the fee and fulfill the request.

Cost	☐ I hereby agree to pay for the copies and postage as long as the total charge is equal to or less than $15.00. Please bill Magnus Health Portal if the total charge will be equal to or less than $15.00. Please contact Magnus Health Portal for authorization if the total cost of records exceeds $15.00.	
	☐ I will not accept any fees charged by my medical provider for the copy of my medical information.	
Authorization	☐ By initialing below, I specifically request the following types of information be included in the records: _____ HIV/AIDS related health information and/or records _____ Behavioral and mental health information and/or records _____ Drug/alcohol diagnosis, treatment, and/or referral information _____ I do not authorize the release of the above information	
	SIGNATURES TO REQUEST ACCESS TO PROTECTED HEALTH INFORMATION: I hereby sign this release of my own free will, knowing that I may revoke the right to authorization at any time during this relationship. Unless otherwise stated, this release will remain in effect two years (24 months) from the date of signature.	
	*Signature of patient or patient representative	
	Printed name of patient's representative	
	Relationship to patient or authority to act for this patient	☐ Self ☐ Spouse ☐ Parent ☐ Guardian
	Date:	

PLEASE DO NOT WRITE BELOW THIS LINE - FOR MAGNUS HEALTH PORTAL USE ONLY

For questions please call us: **(919) 424-4547**
www.magnushealth.com

MHPID: