



MEDICAL RECORDS REQUEST

PATIENT NAME	DATE OF BIRTH	DATE OF EVALUATION
NAME OF EMPLOYER	DATE OF REPORTED WORK INJURY/ILLNESS	

Facility Name XstremeMD Facility Location _____

This medical records request is for CONTINUATION OF CARE.

XstremeMD (XMD) is the occupational medical provider for the above-mentioned patient's employer. We are not affiliated with any Workers Compensation or Insurance provider. XMD providers are directly contracted with the employer to provide updates regarding the above-mentioned patient's plan of care regarding this work injury, personal injury, surgery and personal illness.

Please provide the following information:

<input type="checkbox"/>	Emergency room records including lab results and all diagnostic test results.
<input type="checkbox"/>	Emergency room records, inpatient records, procedural notes, laboratory results, x-ray results, CT scan results, MRI results, EEG results, etc.
<input type="checkbox"/>	Copy of last 2 office visit notes and all diagnostic test results performed.
<input type="checkbox"/>	Copy of last 2 office visit notes.
<input type="checkbox"/>	Other:

Please send these records via fax _____, Attn: XMD Provider
If there are any questions or concerns, please contact the XMD Provider at _____.

NOTE: XMD does not pay for medical records. **We are a third-party Medical Management company involved in coordination of care for the aforementioned patient.**

REQUESTED BY XMD Provider: _____

XstremeMD

DISCLOSURES FOR WORKERS' COMPENSATION PURPOSES

[45 CFR 164.512(l)] Background. The HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers' compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by State or other law.



Request For and Authorization To Release Medical Records or Health Information

Privacy Act

This form authorizes release of information requested in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 in addition to those routine uses disclosures of the information authorized by HIPAA and in accordance with the Notice of Privacy Practice.

Patient Name: _____

Date of Birth: _____ Telephone Number: _____

Information may be released to:	To: XstremeMD 1028 Forum Drive Broussard, LA 70518 Fax: 337-704-0897	For: At request of individual <input type="checkbox"/> Case Management <input type="checkbox"/> Other:

Purpose for Release of Information: _____

Name of health care provider or entity to release this information: _____

Address of above entity: _____

Information to be released:

Expiration Date: This Authorization expires 2 years from date of signature below, unless otherwise revoked in writing.

_____ I hereby authorize the release of All MEDICAL RECORDS AND INFORMATION pertaining to my care and treatment for my Injury or Illness on the visit of _____ (DATE), and any subsequent visits or other encounters for such Injury or Illness, including but not limited to visit notes (history, physical examination and assessment), test results of any kind, radiology reports, referrals, consultant notes, billing records, insurance records, and ALL records created or received by XstremeMD for the care and treatment provided on all dates relative to my Injury or Illness.

_____ Limitation on release of information:

Acknowledgement

I request that health information regarding my care and treatment be released as set forth on this form and understand: 1) This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV related information only if I sign my name on the line below. 2) I have the right to revoke this authorization at any time by writing to XstremeMD at: 1028 Forum Drive Broussard, LA 70518. 3) I understand that signing this authorization is voluntary. I understand that information released pursuant to this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by HIPAA. 4). My treatment will not be conditioned upon my authorization of this disclosure except as allowed by HIPAA for health care services that are solely for the purpose of creating protected health information for disclosure to a third party, like my Employer for purposes such as pre-placement physicals, drug tests, and fitness-for-duty examinations, and failure to provide authorization may result in termination of the patient relationship.

Additional Authorization for release of information:

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information and I expressly authorize XstremeMD to engage in ORAL COMMUNICATIONS regarding my medical records and information as set forth above.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

Patient Signature

Date

Witness Signature

Date