Atrius Health
Part of Optum®

Requesting a Copy of Your Medical Record Information

Atrius Health's Release of Information Department has trained professionals who manage your health information and medical record. Frequently asked questions and answers from patients requesting copies of medical records are listed below. If you have any additional questions, please contact the Release of Information Department during our normal hours of operation. Please note – Our office is not physically accessible to patients.

Mailing Address:
Release of Information Department
Atrius Health
1177 Providence Hwy
Norwood, MA 02062

Hours of Operation:
Monday – Friday: 8:00AM – 4:00PM

Telephone and Fax Numbers:
Tel: 781-292-7700 Fax: 617-421-2626

FREQUENTLY ASKED QUESTIONS

Q. How do I obtain a copy of my medical records?

A. You may access and request records be sent to you via our secure patient portal, MyHealth. Your health information is available 24/7 to view, download, print and request. Simply log into your MyHealth account and complete the Medical Record Request form. Once processed, you will receive a notification that you have a New MyHealth message.

If you do not have a MyHealth account or are authorizing us to send records to a third-party, you may request your records in writing by submitting the completed authorization form on the next page. A completed copy of our authorization form should accompany this FAQ sheet, and can also be downloaded from our website https://www.atriushealth.org/patient-information/access-your-medical-records. Your request should be mailed or faxed to the address above or emailed to medicalrecords@atriushealth.org.Please note that should you email your request, we cannot guarantee your email will be secure.

- *In most cases, patients 18 years or older must sign their own authorization unless a court has appointed the patient a legal guardian or representative. Proof of legal authority/representation is required.*

Requests for Billing information, Pharmacy records, and/or Radiology Images/Films must be made directly to each of those departments

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Q. Is there a cost to obtain a copy of my medical records?

A. There is no charge for requests requested and delivered via MyHealth. Other requests are charged a reasonable cost-based fee for producing and sending copies of medical records pursuant to HIPAA 45 CFR 164.524 and Massachusetts law. Often, an Abstract is sufficient for most patient needs. An Abstract consists of your immunizations, problem list, past medical history, 3 years of office/telehealth visits, lab and diagnostic test results. If you want your entire record or more than an Abstract mailed to you, the rate may increase proportionately and will include postage costs for mailing.

Q. How can I submit my payment?

A. For requests for delivery other than via MyHealth, you will receive an invoice mailed from our copy service, Sharecare, shortly after we receive and process your request. Payment must be received by Sharecare prior to the release of your records.

Q. How soon can I expect the release of my medical record to be completed?

A. Processing time varies depending on the type of request and method of delivery. Requests via MyHealth are usually prepared and released within 3 business days. Other routine requests are usually prepared within 7 business days and released upon receipt of payment. Please note there are instances where a request may take longer to process.

The following scenarios are the most common requiring additional time to process:

- Requests containing information under the 'Information Requiring Specific Consent' box of the authorization form where the appropriate box was not initialed may take longer because we must redact the information needing specific consent.
- Requests for copies of Behavioral Health records that are being released directly to the patient take longer because we are required by law to obtain clinician approval prior to releasing.
- Information prior to 2010 may be delayed because we may need to retrieve a paper chart from storage.

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Authorization to Release Medical Records From Atrius Health

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____
Street Address: _____ Phone Number: _____
City, State, Zip: _____

RECIPIENT INFORMATION

I hereby authorize Atrius Health to release copies of the medical records of the above-named patient, to the following person or facility:

Person/Facility Name: _____ Phone Number: _____
Address: _____ Fax Number: _____
City, State, Zip: _____

PURPOSE

☐ Continuing Care (second opinion/specialist) ☐ Personal ☐ Transfer/Leaving✶ ☐ Other (specify): _____

✶Please provide reason for transfer:
☐ Moved/moving – in-state ☐ Moved/moving – out-of-state ☐ Insurance is no longer accepted ☐ Other (specify): _____

Fee Information

Pursuant to HIPAA 45 CFR 164.524 and state law, we reserve the right to charge a reasonable cost-based fee for producing and sending the copies. Often times, an Abstract is sufficient for most patient care. If you want copies of the entire record or more than an Abstract, the rate may increase proportionately and will include the cost of postage. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).

Delivery Format *(file size restrictions may apply for certain electronic formats)*

▼**Please check one – if nothing is checked, paper copies will be sent via mail** ▼

☐ Secure Email*: _____ ☐ Fax (to Recipient's fax above ☐ Paper ☐ CD
(*To the patient or parent/guardian only. Please print your email address clearly) {— via USPS —}

INFORMATION TO BE RELEASED

☐ **Abstract** (3 years of office/telehealth visits, lab and diagnostic test results)

***OR* CHECK *AND* COMPLETE BELOW**

☐ **Office Visits:** **Date range** _____ **to** _____ **Provider(s)/Specialties:** _____

☐ **Lab results:** **Date range** _____ **to** _____ ☐ **Imaging/Procedure Reports: Date range** _____ **to** _____ ☐ **Immunizations**

☐ **Other** ***(please specify)***: _____

RELEASE OF INFORMATION REQUIRING SPECIFIC CONSENT

The following categories of information may be included in your medical record and ***WILL NOT*** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

CATEGORY	INITIALS	CATEGORY	INITIALS	CATEGORY	INITIALS
Abortion		Behavioral Health		HIV/AIDS Results/Treatment	
Alcohol/Drug Abuse		Genetic Testing		Sexually Transmitted Diseases	

Review and SIGN

I understand that I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Atrius Health. I may revoke this authorization at any time by submitting a written notice of revocation to Atrius Health at the address listed above. The revocation will be effective upon Atrius Health's receipt of my written notice, except that it will not have any effect on any action already taken by Atrius Health in reliance on this authorization. Once Atrius Health has disclosed my health information to the recipient, I understand that Atrius Health cannot control how the recipient uses or rediscloses my health information and the information may no longer be protected by federal or state privacy laws. This authorization will automatically expire 90 days from the date of my signature below unless otherwise specified: _____

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Printed Name of Patient or Legal Representative **Relationship to Patient** – ***Proof of legal authority may be required***