

## [How to Get Your Medical Records](#)

**Complete the *TUP Request to Release Medical Information* form.**

Include the following **required information** to ensure timely processing of your request:

- The patient's full name, date of birth, and the last four digits of his/her Social Security number.
- The patient's full address including street, apartment number, city, state, and zip code.
- A telephone number to contact you if we have questions. You may also include an email address or fax number if available.
- Complete information about the person or medical practice who will receive the medical record:
  - Name of the medical provider or practice (or any other person or entity you designate).
  - Complete address including street address, building, suite number or office number, city, state, and zip code.
  - Telephone number and fax number.
- The purpose of the request.
- The type of information to be released.

### **Fees and Payment**



TUP uses the services of **Verisma Systems, Inc.** (Verisma) to process all requests for medical records. Verisma charges a flat fee of **\$6.50** (six dollars and fifty cents) to patients who want their own records sent to them, or who want their records transferred to a new doctor or practice. This fee must be paid before the records are released. To make payment:

- By credit card--call Verisma at 215-707-5548 or 866-390-7404.
- By check or money order, mail to:
  - **Verisma Systems, Inc., P.O. Box 556, Pueblo, CO 81002.**

### **Processing Your Request**

Verisma responds as quickly as possible to all requests for medical records. Please allow up to fifteen (15) business days for processing. Medical records can be sent by mail on a CD ROM (Compact Disk-Read Only Memory), or by download to your personal computer (PC).

- Medical records are not sent by fax.
- Medical records may not be picked up in person.

**For questions about your records request, call Verisma at 215-707-5548.**

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**TUP's Medical Records Policy:** Medical Records and all the information in them are confidential. Temple University Physicians (TUP) is responsible for safeguarding medical records from unauthorized use, loss, and/or destruction. Medical information/records may be released only with the valid written consent of the patient or the patient's legal guardian, or unless ordered to do so by subpoena or court order.

**Request for an emancipated minor:** an emancipated minor is a person under eighteen (18) years of age who has graduated high school, and/or has been/is married, and/or is or has been pregnant (need not have delivered), and/or has a court order granting emancipation.

**\*Required fields**

## Temple University Physicians (TUP) Request to Release Medical Information

<b>*Patient Name</b>	<b>*Date of Birth</b>	<b>*Last Four Digits of Social Security Number:</b> X X X—X X—____
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<b>*Patient Address</b> (Street, Apartment number, City, State, Zip)		
<b>*Telephone</b>	<b>Fax</b>	<b>Email address</b>

**\*Purpose of Release:**  Transfer records to another provider  Legal Review  School  My own use  Second opinion/consultation

I authorize the following provider/organization to disclose information from my health record as stated below:  Release to patient

<b>*Information to be released FROM:</b>	<b>*Information to be released TO:</b>
<b>*Name</b>	<b>*Name</b>
<b>*Street Address</b>	<b>*Street Address</b>
<b>*Office/Ste#</b>	<b>*Office/Ste#</b>
<b>*City, State, Zip</b>	<b>*City, State, Zip</b>
<b>*Telephone</b>	<b>*Telephone</b>
<b>*Fax</b>	<b>*Fax</b>
<b>Email</b>	<b>Email</b>

**\*Information to Be Released (Check all that apply)**

<input type="checkbox"/> Consultations	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Lab/Pathology/Other Study Reports	<input type="checkbox"/> Cardiac Testing	<input type="checkbox"/> EKG/EEGs
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Physical/Occupational Therapy Reports	<input type="checkbox"/> History and Physical	
<input type="checkbox"/> Medication lists	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Office notes (except psychotherapy notes)	<input type="checkbox"/> Abstract	
<input type="checkbox"/> Records for only these dates of service: <b>From:</b> <b>To:</b> <input type="checkbox"/> All Records <input type="checkbox"/> Other				

**Sensitive Records**—I understand that my records are protected under the Federal Privacy Act, P.L. 93-75, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act 1976, and the Pennsylvania Confidentiality of HIV-Related Information Act and therefore cannot be disclosed without my written consent unless otherwise described in the regulations. I understand that my consent automatically expires as noted below.

<b>AIDS/HIV Treatment</b>	<input type="checkbox"/> Yes, release the records <input type="checkbox"/> No, do not release the records.
<b>Psychiatric Treatment</b>	<input type="checkbox"/> Yes, release the information. My authorization expires thirty (30) calendar days from the date of my signature. <input type="checkbox"/> No, do not release the information.
<b>Alcohol/Drug Use Treatment</b>	<input type="checkbox"/> Yes, release the information—My authorization expires ninety (90) calendar days from the date of my signature. <input type="checkbox"/> No, do not release the information
<b>Genetic Testing</b>	<input type="checkbox"/> Yes, release the records <input type="checkbox"/> No, do not release the records.
<b>Sexually Transmitted Diseases</b>	<input type="checkbox"/> Yes, release the records <input type="checkbox"/> No, do not release the records.

**This authorization expires one (1) year from the date of my signature unless an earlier date is requested or otherwise noted here:**

**Right to Cancel this Authorization:** I understand that I have the right to cancel this authorization in writing (except to the extent that TUP has acted in reliance upon this authorization). Written request to revoke this authorization must be submitted to the Privacy and Security Officer at: Temple University Physicians, Privacy and Security Officer—Compliance Department, 3223 N. Broad Street, Room 412, Philadelphia, PA 19140. **Redisclosure of Information:** I understand that once information is disclosed pursuant to this authorization, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit disclosure. **Right to Refuse to Sign this Authorization:** I understand that generally the person(s) and/or organization(s) listed above whom I am authorizing to use and /or disclose my information may not base my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization. **Right to Inspect:** I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive a Copy of Authorization:** I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

<b>*Patient's or Legal Guardian's Signature</b>	<b>*Date</b>	<b>Time</b> <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
If not the patient, print the name of the person signing this form:	<b>Authority to sign on behalf of the patient:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian Other____ <b>Proof of authorization and identification is required.</b>	

**\*Required fields**

**Temple University Physicians (TUP)  
Request to Release Medical Information**

<b>*Patient Name</b>	<b>*Date of Birth</b>	<b>*Last Four Digits of Social Security Number:</b> X X X-X X-__ __ __ __
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Complete page two (2) only for verbal consent by a patient unable to sign, and when language interpretation is required.

This is a verbal consent given by a person physically unable to sign.

Print the name of first witness:	Date	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Signature:		

Print the name of second witness:	Date	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Signature:		

<b>Interpreter's Statement</b>	
I have interpreted: <input type="checkbox"/> the information explained to the patient by the healthcare provider accepting this release, and answered the patient's questions. I have done this using: <input type="checkbox"/> American Sign Language or <input type="checkbox"/> by speaking in the _____ language. To the best of my knowledge, he/she understood this interpretation.	
Interpreter's Name:	Record #: