MEDICAL AND/OR BILLING RECORDS REQUEST FORM

A patient or their legal representative can complete this form and return it to HME Specialists (HMES) to authorize the disclosure of protected health information (PHI) to designated parties other than the patient. All fields must be completed for the form to be approved.

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____ **Patient ID:** _____

City, State, Zip _____

1. I authorize HMES to disclose the health information of the individual named above to the individual or organization listed below, who is authorized to receive and utilize the disclosed information:
   - Individual / Entity Name: _____
   - Fax #: _____
   - Email Address: _____
2. The type and amount of information to be used/disclosed is:
   - ☐ Entire Record (Medical and Billing)
   - ☐ Billing Records, only
   - ☐ Medical Records, only
   - ☐ Other *(minimum necessary information)*: _____
3. The information will be disclosed for the following purpose(s):
   - ☐ Continuity of Care
   - ☐ Legal Purposes
   - ☐ Other: _____
4. I understand that information used or disclosed under this authorization may lose federal and/or state law protection once received by the recipient.
5. I have the right to revoke this authorization at any time by submitting a written request to HME Specialists, LLC., and I understand that the revocation will not take effect until HMES receives the written revocation notice and processes the request in my account. Additionally, I understand that my request to revoke the authorization does not apply to situations where my insurer carrier(s) is legally entitled to contest a claim under law/policy.
6. I understand that only upon request, will I get a copy of this authorization form after I sign it and submit to HMES.
7. I understand this serves as voluntary consent and that payment or eligibility to receive services/supplies from HMES will not be conditioned on whether (or not) I sign this authorization.
8. I understand **this authorization will expire twelve** *(12)* **months from the date of signature if an expiration date or event/condition is not specified**.
   a. Expiration Date: _____
   b. Expiration from Event/Condition: _____

Patient's Signature _____ **Signature Date** _____

***Patient Personal Representative** – *Complete this section if the patient is legally incapacitated or otherwise unable to provide authorization for the disclosure of their PHI **and** provide relevant legal or court documents authorizing disclosure of their PHI, as required by applicable state and federal laws, including but not limited to HIPAA regulations.*

Patient's Personal Representative's Name *(PRINTED)* _____ **Relationship to Patient** _____

Patient's Personal Representative's Signature _____ **Signature Date** _____

Email this completed form to *Compliance@hmespecialists.com* or send it via mail/fax using the information below.