John K. Bradway, M.D., A Division of OSNA, PLLC
10213 N. 92nd Street, Suite 101
Scottsdale, AZ 85258
Phone: (480) 860-6005 Fax: (480) 860-1882

Patient Name:_____ DOB:_____

Medical Records Request Fee

The office of John K. Bradway, M.D., will provide your records to you once you have completed the Patient Authorization for Use / Disclosure of Protected Health Information (PHI) form. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within 30 working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20	$15.00
Pages 21-50	$25.00
Pages 51+	$40.00
X-Rays on CD	$10.00
X-Rays on paper	$1.00 per page

Form and Letter Fee

This is to notify you that the office of John K. Bradway, M.D., will apply a fee of $20.00 to your account for patient, companies, family members, insurance carriers or other person requesting form and/or letters to be completed.

Forms include, but not limited to FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agents, gyms, etc.

In order to comply with federal laws including HIPAA, as well as Arizona state and federal statues, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. You can find this form on our website or you can contact our office and we can mail or fax the form to you. Please be sure to sign the form. Unsigned requests cannot be processed.

_____ _____

Signature of patient or responsible party Date

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Patient Authorization for Use / Disclosure of Protected Health Information (PHI)

Patient's Name: _____ DOB: _____

SSN: _____ Previous Name: :_____

I request and **authorize** John K. Bradway, M.D., to release healthcare information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and **authorization** applies to:

- ❑ Healthcare information relating to the following treatment, condition, or dates of treatment: _____
- ❑ All healthcare information
- ❑ Other: _____

_____ _____
Signature of patient **or** patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

This authorization expires one month from the date of signature; I may revoke this authorization to the extent allowed by law. If I do, I understand that John K. Bradway, M.D., may have already released information about me after I gave permission. I know that revoking this authorization would not prohibit any release of information by John K. Bradway M.D., in reliance on my original authorization. I can revoke this authorization by writing a letter to John K. Bradway M.D., it must say that I want to revoke my authorization to disclose the patient's healthcare information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative for healthcare) must sign and date the letter. I am aware that fees may apply for medical records request.

Once John K. Bradway M.D., gives out the information that I want released, I know that John K. Bradway M.D., has no control over the information. The individual or organization that I authorized to receive the information might re disclose it. Federal or state privacy laws may no longer protect the information.