

RESPONSE TO REQUEST FOR MEDICAL RECORDS

To:	Custodia	Custodian of Records			Medical Records Dept.
	< <name< th=""><th>of Recipient>></th><th></th><th>Pages:</th><th></th></name<>	of Recipient>>		Pages:	
Phone:	< <recipi< th=""><th colspan="3"><<recipient phone="">></recipient></th><th>866-686-1717</th></recipi<>	< <recipient phone="">></recipient>			866-686-1717
Fax:	< <fax of<="" th=""><th colspan="3"><<fax of="" recipient="">></fax></th><th>484-398-7210</th></fax>	< <fax of="" recipient="">></fax>			484-398-7210
□URGENT □ FOR REVIEW □ PLEASE COMMENT □ PLEASE REPLY □ PLEASE RECYCLE					

Re: <<Patient Last>>, <<Patient First>> <<Recipient Request ID>>

ATTN: Custodian of Records:

We have received your request for medical records for the above-named patient. It is our practice to have physicians verify their relationship to the patient. Please complete the attached form to confirm the physician's relationship to the patient, and that the records being requested are for the purpose of continuity of care.

The supporting documentation can be returned using one of the following methods:

Mail Fax Email

ATTN: Jessica McDwyer (484) 398-7210 medicalrecords@tridentcare.com

TridentCare

930 Ridgebrook Road, 3rd Floor

Sparks, MD 21152

Please contact our Medical Records Department at medicalrecords@tridentcare.com or our toll free number (866) 686-1717 if you have any questions.

Regards,

Medical Records Department
TridentCare Health Services

COMEDENTIALITY NOTICE: THIS FACSIMILE (INCLUDING ANY ACCOMPANYING DOCUMENTS) IS INTENDED FOR THE USE OF TRIDENTCARE OR THE USE OF THE NAMED ADDRESSE(S) TO WHICH IT IS DIRECTED, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED OR OTHERWISE CONFIDENTIAL. IT IS NOT INTENDED FOR TRANSMISSION TO, OR RECEIPT BY, ANYONE OTHER THAN THE NAMED ADDRESSE(S) OR PERSON(S) AUTHORIZED TO DELIVER IT TO THE NAMED ADDRESSE(S). IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE REPORT THE ERROR BY CALLING THE TRIDENTCARE PRIVACY OFFICE TOLL FREE AT 866.686.1217, AND PROVIDING YOUR NAME, TELEPHONE NUMBER AND THE DATE. ONCE YOU HAVE REPORTED THE ERROR, SOMEONE FROM THE PRIVACY OFFICE WILL CONTACT YOU WITHIN ONE BUSINESS DAY. THEY MAY ASK YOU TO FAX BACK THE INFORMATION YOU RECEIVED SO THAT THE COMPANY CAN CORRECT ITS RECORDS AND PREVENT FURTHER MISCOMMUNICATION. PLEASE KEEP THE INFORMATION IN A SECURE PLACE UNTIL YOU ARE CONTACTED BY THE PRIVACY OFFICE AND COMPLETE THE TRIPN OF THE INFORMATION OF THAT OFFICE ONDE. PLEASE DESTROY ALL COPIES OF THE MISTAKENLY SENT INFORMATION. WITHOUT

FORWARDING IT. THANK YOU FOR YOUR COOPERATION.



Please complete and return to Medical Records via fax to 484-398-7210 or via email to medicalrecords@tridentcare.com.

Section A – Patient Information (individual whose information will be released):					
Patient Name: (Last, First, Middle Initial, Title)	Date of Birth: MM/DD/YYYY				
Section B – Authorized Person (person(s) or organization to receive pa	atient's information)				
(Please include the name, address, email address, and phone number of the person(s), organization to whom the patient's information will be sent)	category of persons or				
Section C – Information to be Released: (type of information to be sen	nt).				
1. Description of the Information to be Disclosed : (Type of information that will types of information that apply to this request)					
X-ray Images Ultrasound Images Lab Results F	Radiologist Report				
Medical Record Other:					
2. Date(s) of Treatment and/or Service related to the Information to be Disc					
of dates that TridentCare provided treatment or service(s) to the patient related to	the requested information).				
From:/ To:/ MM					
Section D – Method of Delivery					
Email <i>(preferred)</i> :	(email address)				
Fax (reports only):	(fax number)				
CD / USB via FedEx (circle one)					
PACS transfer (ONLY to be completed by provider with an existing PACS conne	ection)				
<u> </u>	,				
Section E – Treating Physician's Signature: (please sign and date this	<u>-</u>				
I, the undersigned, certify that the above-named patient is under my care and t					
pertinent to treatment and coordination of care or for another HIPAA-complian required by applicable state or federal law, the patient and/or responsible party					
release of information for continued treatment or other HIPAA-compliant purpo	•				
Signature of Physician or Authorized Clinical Staff:	Date: (MM/DD/YYYY)				
	<u> </u>				
Physician or Organization Printed Name and Address:					