



MEDICAL RECORDS REQUEST

Patients and residents have the right to their health information kept at Jennings. Formal requests for this information may be made to Jennings' medical records staff.

If an individual desires to obtain or would like someone else to obtain any information from his/her medical record, Jennings requires a complete written authorization form that authorizes Jennings to disclose such information.

The required forms are included within this packet. If you have additional questions, please feel free to contact your social worker at Jennings by calling (216) 581-2900.



Jennings

Medical Record Copy Costs and Payment

➤ Requests made by patients and their representatives:

\$3.07 per page for the first 10 pages,

.64 cents per page for pages 11-50,

.26 cents per page for pages numbering more than 50

The actual cost of postage may be charged

➤ Requests made by someone other than the patient or patient's representative:

An initial fee of \$18.91 to compensate for the records search

\$1.24 per page for the first 10 pages,

.64 cents per page for pages 11 through 50,

.26 cents per page for pages numbering more than 50

The actual cost of postage may be charged

Jennings Center for Older Adults accepts these forms of payment for copying records:

- Check
- Money Order
- Cash
- Credit Card (Only in Person)

Please make checks and money orders payable to Jennings Center for Older Adults.

Payments may be sent via mail or given in person.

Mailing Address:

Jennings Center for Older Adults

ATTN: MEDICAL RECORDS DEPARTMENT

10204 Granger Road

Garfield Heights, OH 44125

Please make sure all payments are mailed and/or given to the attention of the Medical Records Department.



JENNINGS COPY

(ORGANIZATION TO KEEP THIS PAGE WITH RECORD REQUEST)

MEDICAL RECORDS COPY COSTS

I have been informed of the charges for the copying of Medical Records in advance of requesting the records. I understand that in most cases, the exact number of pages is unknown until the copies are made.

Printed name of resident

Printed name of individual requesting records

Signature of individual requesting records

Date



Authorization for the Release of Health Information

I hereby authorize Jennings Center for Older Adults to disclose my individually identifiable health information as described below.

Resident Name	Social Security Number	Date of Birth
Name & address of person(s) or organization requesting records if different than resident:	Names & address of person(s) or organizations to receive the records:	
_____	_____	
_____	_____	
_____	_____	

_____ I will review the records at Jennings

_____ I am requesting that Jennings copy the following records, and send the records to the above address.

Information Requested (please initial)

I am requesting the following records from the resident's medical record that were created between _____ and _____:

_____ Dining Services	_____ Life Enrichment	_____ Nursing Notes
_____ Physician Orders	_____ Physician Progress Notes	_____ Care Plans
_____ Discharge Summary	_____ X-ray Reports	_____ Lab Results
_____ Other: _____		
_____ Other: _____		

Purpose for which records will be used: _____



Legal Authority for Request (please initial)

_____ I am the resident noted above.

_____ I am the resident's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the resident's medical records. I understand that the resident's DPAHC is effective only when the resident's attending physician has determined that the resident has lost the capacity to make informed health care decisions.

_____ I am the resident's legal guardian, and I have attached to this authorization a valid guardianship from a probate court.

_____ If the resident is deceased: I am the executor/administrator of the resident's estate, and I have attached to this authorization a valid appointment as such from a probate court.

_____ The resident has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.

_____ The resident's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the resident's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a power of attorney or probate court order.

Understandings & Agreements of Requestor

1. This authorization is voluntary and I understand that Jennings Center for Older Adults cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. This authorization will expire (e.g., 60 days) from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying Jennings Center for Older Adults in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against Jennings Center for Older Adults for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Jennings Center for Older Adults if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with Jennings Center for Older Adults.
6. I understand that I must provide Jennings Center for Older Adults with at least twenty-four (24) hours notice before coming to Jennings Center for Older Adults to review records.



Jennings

7. I understand that after I have reviewed the records, I must provide Jennings Center for Older Adults with at least two (2) working days advance notice of any copies of the records that I would like to pick up at Jennings Center for Older Adults.

8. I understand that if I request that records be copied and sent to me that Jennings Center for Older Adults will make a good faith effort to send those records to me in reasonable amount of time.

9. I understand that if I wish to have copies of records made, then Jennings Center for Older Adults will assess a fee for copying the records.

10. Jennings Center for Older Adults will notify me of the total amount due for copying and shipping of the requested records; I agree that Jennings Center for Older Adults will only send me the requested information once it has received payment in full for those costs.

Signature of person making request

Date

Printed name of person making request