POND MEDICAL CENTER INC.

Dear Patient(s),

Attached is the records release that I need signed by the patient requesting the records unless the patient is a minor then I will need the legal guardian to sign for the release. Please read the release carefully. Please indicate if I can email the invoice, if you include your email I need to know if I am also emailing your records.

I have included here the per page cost for the records:

Ohio Revised Code Section 3701.742
For the first ten pages: $3.25 per page
For pages eleven through fifty: $0.68 per page
For pages fifty-one and higher: $0.27 per page
and the actual cost of shipping

I am offering a 50% discount if you want your records emailed or put on flash drive. The cost for a flash drive is $4.00 please indicate with a check mark on the release if you want it on a flash drive. Once I know how you would like your records sent I will email or mail you an invoice with the cost breakdown. Once the invoice is paid I will send your records.

I am also offering a summary of your chart for $6 this covers the printing of the summary and the mailing costs. The summary of your chart will include every medication Dr. Pond has given you; all of the diagnosis Dr. Pond has ever diagnosed you with, any immunizations we have ever given you. Your most recent EKG and spirometry as well as most recent labs. Please indicate that on the release as well.

If you have any questions please email me at pmc.kvernon@gmail.com or call the office at 614-771-8811. I will be checking messages frequently. Thank you!

Best wishes,

Kaslyn Vernon, CMA

Pond Medical Center Inc.
5130 Blazer Parkway, Dublin, Ohio 43017
Phone: (614)771-8811 Fax (614) 771-8858

POND MEDICAL CENTER INC.

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of substance abuse, psychiatric /mental health information or H1V/AIDS information) of:

Patient's Name:_____
Date of Birth:_____

Persons/Organization Authorized to Release the Information:

Pond Medical Center Inc.
5130 Blazer Parkway
Dublin, OH 43017
Phone: 614-771-8811

Person/Organization Authorized to Receive the Information:

Name:_____ ____
Address:_____
_____
Phone:_____
Fax:_____
Email:_____

☐ Use email for invoice and records
☐ Use email for invoice ONLY
☐ I would like my records on a flash drive

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to a third party and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization.

I understand that if I request my records to be emailed it is NOT HIPAA COMPLIANT and Pond Medical Center Inc. will not be held responsible for any breach related to but not limited to the access of personal health information.

This authorization and request is fully understood and is made voluntarily on my part. I release the above- named facility of any legal liability that may arise from the release of the information requested

☐ I would like a summary of the chart ONLY ☐ I would like the complete chart

Patient/guardian Signature:_____ Date:_____

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. THIS AUTHORIZATION WILL EXPIRE AUTOMATICALLY 60 DAYS FROM THE DATE SIGNED. Cancellation of the authorization prior to the 60-day limit must be made in writing and sent to:

Pond Medical Center Inc.
5130 Blazer Parkway, Dublin, Ohio 43017
Phone: (614)771-8811 Fax (614) 771-8858