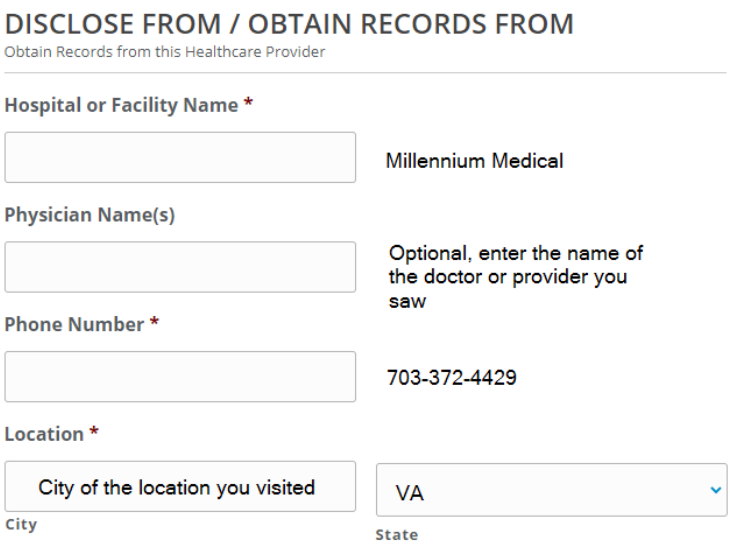
Completing Patient Requests Online

Patients can request their own records on the ScanSTAT website:
https://www.scanstat.com/patient-record-request/

Please note, only patients can complete this form, and indicate where they want records sent, if sending to a third party. For Attorneys or third party or Insurance who want medical records for their clients or other parties, Please get a signed authorization from the patient and email the authorization to mmcare4u@gmail.com or fax it to location fax number found on our website @ https://millenniummedicalcare.com/

1. **To complete the form, enter the name and contact information for the requestor, or the person who will receive the records, if that person is not you, the patient**

2. **Enter Millennium Medical's information, including full name, phone number, city and state**



3. **If you are requesting records sent to yourself, check yes. If you are requesting your records sent to a third-party, check no and enter your name, date of birth, as well as your phone and email**

PATIENT INFORMATION

Same as Above *

- ○ Yes
- ◉ No

Patient Name *

Date of Birth *

Month | Day | Year

Patient's Phone

Patient's Email

4. **Enter Dates of Treatment, or the date range of records requested. If all records are requested, enter date of birth as beginning date of treatment, and enter today's date as ending date of treatment**

REQUESTED INFORMATION

Dates of Treatment

Please provide a copy of patient's medical records for the following date range:

Beginning Date of Treatment *

Ending Date of Treatment *

5. **Check the types of records requested**

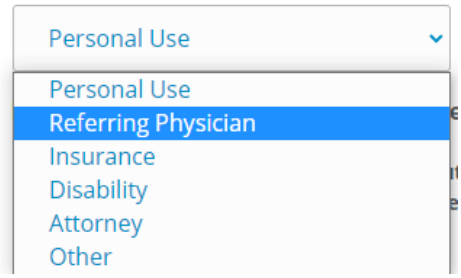
Records to Release *

- [ ] COVID-19 Test Results
- [ ] Physician Documents (Pertinent Reports and Test Results for Doctors)
- [ ] Patient Personal Documents (All Doctor's Reports and All Test Results)
- [ ] Emergency Room
- [ ] Doctor's Notes
- [ ] Discharge Summary
- [ ] Nurse's Notes
- [ ] EKG
- [ ] Labs
- [ ] Immunizations
- [ ] Admission Sheet
- [ ] Physician's Orders
- [ ] Pathology Reports
- [ ] History/Physical
- [ ] Office Notes
- [ ] Progress Notes
- [ ] Operative Reports
- [ ] Consultation
- [ ] Radiology
- [ ] Radiology Films / Imaging
- [ ] Complete Copy (this type of request may include 100s to 1000s of pages)

Check any and all records requested

6. **Indicate why records are requested**

Disclosure Purpose *



7. **Check and agree to the following terms, then indicate if you want records emailed or mailed**

Please indicate your acceptance by checking the following boxes: *

- [ ] I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR 164.508(c)(2)(i)).
- [ ] I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR 164.508(c)(2)(i)).
- [ ] I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- [ ] I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR 164.508(c)(2)(i)).
- [ ] I understand my request will not be processed until the patient's identity has been confirmed by telephone

DELIVERY FORMAT

Deliver Records By *

- ○ Secure Electronic Delivery
- ○ Mail Delivery

8. **Type your name and indicate relationship to patient: self, parent, legal guardian, or healthcare power of attorney. If you are the patient, click Self**
9. **Chose a length of time that the authorization will remain valid (if you select 30 days, authorization will expire in 30 days, etc), then type your name to electronically sign the authorization, and check the Confirmation and Acknowledgement of Disclosure**

AUTHORIZATION

Name *

First

Last

Relationship to Patient *

Self

Patient authorization shall remain valid for: *

- 30 Days
- 60 Days
- 90 Days
- 180 Days
- 365 Days

This authorization will expire after the selected validity period (above) as authorized by my signature unless I revoke the authorization prior to that time. *

E-Signature

Patient or Legally Authorized Representative

Confirm Acknowledgement of Disclosure *

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to disclosure of medical records.

10. Add Additional Comments if needed (optional) and click Authorize Release

Additional Comments (optional)

AUTHORIZE RELEASE