ResolveROI
RELEASE OF INFORMATION

Altair Health Information about Medical Records Release of Information (ROI) Processing

To ensure optimal compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, ResolveROI processes all requests for medical records and protected health information that come into Altair Health.

If you are a patient or third party requesting information, read on to learn more.

If you are a patient:

- You can request medical records online by completing the Medical Records Request form found at altairhealth.com/medicalrecords.
- You can also obtain a request form at an Altair Health office or by calling 973.285.7800. You can fax the completed form to 973.285.7809 or bring it into one of our offices. Please do not submit your request directly to ResolveROI.
- Your request will be processed within 5-7 business days. You will be notified when your request has been processed and your records have been delivered.
- There is a charge of $6.50 for records requested for your use delivered directly to you. Records delivered directly to your healthcare provider are sent at no charge. If you request records be sent to a third-party for non-healthcare purposes, the third party is invoiced at applicable rates with payment due in advance and payable to ResolveROI. Requests for X-ray, MRI or images on disc are $20 per disc (+ delivery cost). You will receive an invoice for any charges associated with your request.
- To confirm the status of your request or if you need assistance from ResolveROI, call 844.887.8109 or email Support@ResolveROI.com.
- Your requested records will be promptly delivered by the method you selected on your request form.

If you are a third party:

- Requests for medical records must be submitted to Altair with proper documentation and patient authorization (if required). All requests must be delivered to an Altair office or faxed to 973.285.7809. They may not be submitted directly to ResolveROI.
- All requests are processed by ResolveROI within 10 business days (+ mail time). At that time, an invoice will be sent to you by email, fax and/or mail. The invoice indicates records are immediately available for download upon payment receipt. Credit card payments are accepted online or by phone. Check payments are accepted by mail.
- You will be invoiced for records at regulated rates. You will be invoiced for any films, images or x-rays provided by Altair at the cost of $20 per disc. As noted above, your payment must be received before you can access the records, which are immediately available for download upon payment receipt.
- You can securely download records at https://requesters.resolveroi.com/. Download instructions and other important information are included on the requester notifications and invoices.
- If you need assistance, contact ResolveROI at 844.887.8109 or email Support@ResolveROI.com. If you are on the phone with an Altair representative, he/she can transfer your call internally.
- You can cancel your order at no cost if your cancellation request is received prior to the order being processed. Once the request is processed (invoiced), a cancellation fee equal to (the greater of) $20 or 50% of the original invoice amount is required.
- Records are never withheld, but if you have a significantly past due invoice(s), you may have to contact ResolveROI Support prior to downloading the records. You may also have to contact ResolveROI Support if you fail to download records in a timely manner and per HIPAA guidelines. If this occurs, you will need to make a new request.

CONTACT INFORMATION

ResolveROI Support
Main Support Tel: 844.887.8109
Emails: support@ResolveROI.com

Altair Medical Records:
Medical Records Tel: 973.285.7800 (select medical records prompt)
Medical Record Fax: 973.285.7809

Altair Health

Authorization for Use & Disclosure of Protected Health Information

Please fax this form to (973) 285-7809 or deliver to 310 Madison Ave, Suite 300 · Morristown, NJ 07960

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: _____

Street Address: _____ Tel # (cell): _____

City, State ZIP: _____ Tel # (alternate): _____

Email Address: _____ Physician: _____

DISCLOSURE:

I request my records to be delivered by: ☐ Electronic Delivery ☐ Mail (paper) ☐ Pick Up (paper) ☐ Fax to Healthcare Provider

I hereby authorize Altair Health to disclose my Protected Health Information to:

Facility/Individual Name: _____ Relationship: _____

Attention: _____ Fax #: _____

Street Address: _____ Tel #: _____

City, State ZIP: _____ Email Address: _____

PURPOSE OF REQUEST: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ _____

TREATMENT DATES: for Information to be released: **From (date):** _____ **To (date):** _____

TYPE OF INFORMATION TO BE RELEASED:

☐ Office Notes ☐ Complete Health Record ☐ Radiology Reports ☐ Labs

☐ Physical Therapy Notes ☐ Itemized Billing Statement ☐ X-ray, MRI, Images (on disc only) ☐ Other: _____

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE: I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check one:*** Yes No

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION: Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorizing. **This Authorization will expire on (date)_____, or 90 days from signature date**.

RE-RELEASE: I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

COST OF MEDICAL RECORD COPIES: Medical record copies delivered directly to the patient for personal use will cost $6.50. Medical record copies delivered directly to a healthcare provider will be free of charge. Medical record copies for all other purposes will be charged at applicable rates with payment due in advance and payable to Resolve ROI. Requests for X-ray, MRI or images on disc are $20 per disc (+ delivery cost). **For questions regarding this request please contact Resolve*ROI* at (844) 887-8109 or Support@ResolveROI.com**.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE: By signing below, you authorize your healthcare provider identified above to release your protected health information and acknowledge and understand the terms of this Request for Access to and Authorization for Use and Disclosure of Protected Health Information. This consent permits Altair Health to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, Altair Health is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE Altair Health, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

Print patient's name: _____

Signature of patient or legally authorized person: _____ **Date:** _____

Relationship to Patient: _____