Dear Health Information Specialist,

I am requesting that a copy of my complete medical records and itemized account billing statements be sent to my authorized agent, Mass Tort Records Specialists, LLC, P.O. Box 850, Blue Springs, MO 64013, under the HIPAA Privacy Rule.

Please allow this letter serve as a HIPAA-compliant authorization which will expire one year (12 months) from the date on which it was signed.

These medical records and itemized account billing statements are being requested for personal use.

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse, developmental disabilities and genetic information.

I understand that I have the right to revoke this authorization at any time by presenting my written revocation to the health information management department of the facility documents are requested from, and that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand that the covered entity requesting records from may not condition treatment, payment enrollment, or eligibility for benefits on whether I sign the authorization. 45 CFR 164.508(C)(2)(ii). I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I authorize my medical providers, their employees and agents to provide to and to discuss with my agent, my medical records, billing records, treatment, diagnosis, prognosis and other matters relating to my health record.

Pursuant to 45 CFR 164.524(c)(2)(ii), I request access to the records in electronic format. I request that you provide the records in electronic Adobe .pdf format via email to karla@lfg-kc.com; niki@lfg-kc.com; or by mailing appropriate media through the US mail service or similar service. Pursuant to Federal Regulation, I will direct that payment of $6.50 be made upon receipt of the electronic copy. If the charge for records in electronic format exceeds the amount specified by Federal Regulation, forward the itemized cost-based fee to be charged at your earliest possible moment to my attorney and their agent. **Please note – I am requesting notarized affidavits and/or certification for records and/or bills. It is within my right to request such and I specifically ask for certified records.

Federal law specifically disallows the charges authorized under Missouri law for producing medical records, 45 CFR 164.524(c)(4). If the facility does not maintain the records in electronic format, please itemize the fee for providing records by returning an accounting of the labor for copying the medical records, supplies, and mailing cost.

HIPAA requires that these records be forwarded in thirty (30) days or less. If you are unable to provide the records within this time period, please inform my attorney and their agent in writing of the reason for the delay and date by which the records will be provided. Please note a photocopy of this letter is as valid as the original.

Sincerely,

Client Signature: _________________________

Printed Name: _________________________

Date: _________________________
To Whom It May Concern:

Please be advised that I have appointed Mass Tort Records Specialists as my agent for collection of my medical/billing records for my personal use.

I am attaching hereto a HIPAA compliant Hi-Tech letter in which I direct you to release all documents directly to Mass Tort Records Specialists for production of my documents in electronic format. If electronic production is not available, please advise Mass Tort Records Specialists PRIOR to sending the documents. They have my authorization to pay the $6.50 fee only and will need approval for anything else. Again, please contact them directly regarding any invoices outside of the pre-approved $6.50 fee as they are protecting my interests and acting on my behalf as I have directed.

Legal Fulfillment Group will also receive and pay all invoices for documents collected on my behalf. Any questions regarding the request for the documents should be directed to Mass Tort Records Specialists at their contact number of 816-282-2940. Their fax number is 816-293-9757. The email address for MTRS is orders@mtrs-us.com. Mailing address is PO Box 850, Blue Springs, Missouri 64013. Physical address is 400 SE Weiss Circle, Lee’s Summit, MO 64063.

In an effort to address any argument that my request is not for my personal use, I will remind you that personal use is dictated by the type of requestor. I agree if an insurance company is requesting my records, their use is not personal. However, when a patient such as myself requests his or her own medical records it is always deemed a personal use.

If you fail to provide my medical records to my agent pursuant to the Hi-Tech Act, your refusal will be viewed by myself and under the law as a violation of the Hi-Tech Act. I, as the patient, will personally report your refusal to abide by the Hi-Tech Act to the appropriate authorities for prosecution.

Please contact my agent directly for any and all questions regarding this request.

Thank you,

Client Signature: ____________________________

Printed Client Name: ____________________________

Date: ____________________________