



Healthcare Everywhere Medication

- ? Enter Information
- ? Medical Release Form
- ? Update Information
- ? Multimedia
- ? Print
- ? User Guide

Medical Release Form

Provide the release form and the letter below to all health care providers that hold your records. You can be charged a reasonable fee for copying records. You may also be charged for postage if records are mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, but you may request an extension for good reason. [Note: HIPAA also allows you to request a summary of your records. If you prefer a summary, you should agree to a fee beforehand.]

Medical Records Release

Form

Letter

First Name*	Last Name*
<input type="text"/>	<input type="text"/>
Email Address*	Doctor Name*
<input type="text"/>	<input type="text"/>
Home Address*	City*
<input type="text"/>	<input type="text"/>
Zipcode/Postcode*	Country*
<input type="text"/>	<input type="text"/>

Slide 1

Text Captions: Clicking the "?" will display information related to the associated section

Healthcare Everywhere Medical Release Form

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Enter Information

Enter Information

Your HCE Medical USB lets you provide doctors and other healthcare providers with valuable information that will help improve your quality of care.

Your HCE Medical USB can hold hundreds of pages of your medical history. Small enough to be carried with you at all times, your records are compatible with most computers worldwide. Your critical medical records will be viewable by any authorized user – rest assured your personal data is password protected so only you and those you designate can see it. All your information is maintained by you, guaranteeing your privacy and making updates a snap.

Slide 2
Text Captions: Clicking on the "x" will close the window

Provide the release form and the letter below to all health care providers that hold your records. Under HIPAA you may be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason. [Note: HIPAA also allows you to request a summary of your medical records. If you request a summary, you should agree to a fee beforehand.]



Medical Records Release

Form

Letter

First Name*	Last Name*	Date Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address*	Doctor Name*	
<input type="text"/>	<input type="text"/>	
Home Address*	City*	State*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Zip Code/Postcode*	Country*	
<input type="text"/>	<input type="text"/>	
Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	

I consent to the release of any positive or negative test result for AIDS or HIV infection, antibody

Slide 3

Text Captions: Clicking on tabs will display additional content

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Medical Records Release

Form

Letter

Your name]

Your address]

Date]

Name of care provider or facility]

Address]

RE: [Your medical identification number or other identifier used]

Dear

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

Provide the release form and the letter below to all health care providers that hold your records. Under HIPAA you may be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason. [Note: HIPAA also allows you to request a summary of your medical records. If you request a summary, you should agree to a fee beforehand.]



Medical Records Release

Form

Letter

First Name*	Last Name*	Date Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address*	Doctor Name*	
<input type="text"/>	<input type="text"/>	
Home Address*	City*	State*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Zip Code/Postcode*	Country*	
<input type="text"/>	<input type="text"/>	
Phone Number*	Fax Number*	
<input type="text"/>	<input type="text"/>	

I consent to the release of any positive or negative test result for AIDS or HIV infection, antibody

Slide 5

- Enter Information
- Medical Release Form
- Update Information
- Multimedia
- Print
- User Guide
- Exit

Medical Release Form

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Medical Records Release

Form

Letter

First Name*	Last Name*
Email Address*	Doctor Name*
Home Address*	City*
Zipcode/Postcode*	Country*
Phone Number*	Fax Number*

Slide 6
Text Captions: Review of the main navigation will present many options for navigating the application.

- Enter Information
- Medical Release Form
- Update Information
- Multimedia
- Documents**
- Photos
- Finger Prints
- Print
- User Guide
- Exit

Medical Release Form

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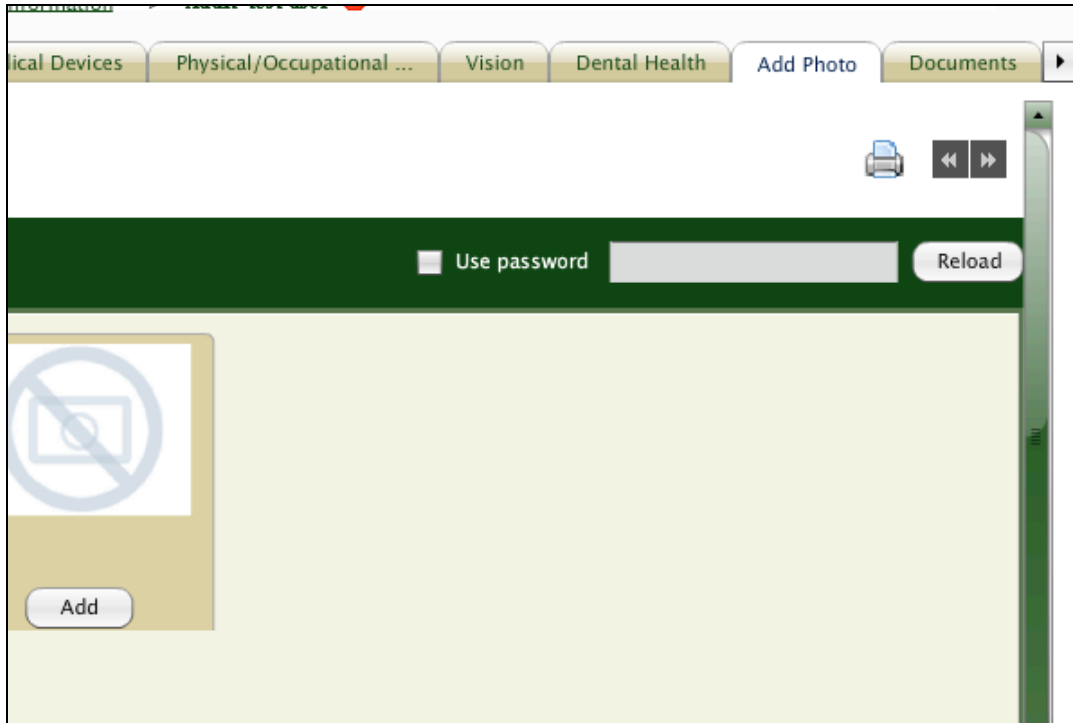
Medical Records Release

Form

Letter

First Name*	Last Name*
Email Address*	Doctor Name*
Home Address*	City*
Zipcode/Postcode*	Country*
Phone Number*	Fax Number*

Slide 7
Text Captions: Many section display additional sub-navigation



Slide 8

Text Captions: Available on most forms are optional navigational arrows. Clicking the arrows will forward and back one form at a time.



Slide 9