Medical Record Transfer Instructions for Direct Primary Care Members

Sending Medical Records to Atrium Health:

- Complete the Marathon Health Authorization form for release of your medical records.

- Atrium Health Submittal Information for the form:
    - Fax Submission: 704-446-6037
    - Email Submission: medicalrecordsROI@atriumhealth.org
    - Mailing Address: PO BOX 32861 Charlotte, NC 28232
    - Website: https://atriumhealth.org/for-patients-visitors/medical-records
    - Phone: 704-667-9500

- Submit the completed authorization form to medicalrecordsgroup@marathon.health

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ _____
Last First MI Date of Birth

I hereby authorize:
(Name and contact information of sending party)

_____
_____
_____
_____

To Release Information to:
(Name of recipient and mailing address, email address, and fax number)

_____
_____
_____
_____

Purpose of Disclosure:

- ☐ Medical treatment/Continuing Care
- ☐ Billing or Insurance
- ☐ School
- ☐ Legal
- ☐ Determination of Disability
- ☐ Personal Use
- ☐ Other (specify): _____

Information To Be Released:

- ☐ Specific dates of treatment: from _____to _____
- ☐ All Health Information

OR the following checked categories:

- ☐ Discharge summary
- ☐ HP Exam/Initial Evaluation
- ☐ Consultation Reports
- ☐ Biometric Screening Data
- ☐ Progress/Provider Notes
- ☐ X-Ray Reports
- ☐ X-Ray Films/MRI
- ☐ Diagnostic Test Reports
- ☐ Procedure Reports
- ☐ Lab Reports/Pathology
- ☐ Orders
- ☐ Outside Provider Records
- ☐ Past/Present Medications
- ☐ Correspondence
- ☐ Billing
- ☐ Other: _____

Your initials are required to release the following information:

_____Mental Health Records _____Drug, alcohol, or substance abuse records _____Genetic information

_____Psychotherapy Records _____HIV/AIDS Test Results/Treatment

Acknowledgement of Understanding:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand Marathon Health may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I am entitled to receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

_____ _____
Signature of Participant or Representative Today's Date

Relationship to patient (circle one): Self Parent Legal Guardian Other: