MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

MRO

Phone: (610) 994-7500 Opt. 1
Fax: (610) 962-8421

Request ID: 22144407
Tracking #: ILPHSPRC77J9M

Jeffrey Bodin
Personal
528 Beau Chene Drive
Mandeville, LA 70471

Track your request at www.roilog.com.
Enter your Tracking # and Request ID.

Date: 6/20/2018
Phone:
Fax:

Notice of an Issue Regarding Your Medical Record Information Request

MRO works with your healthcare provider to process requests for copies of medical records on their behalf. As their business partner, it is our pleasure to serve you! Please note that there is an issue with your request (see detail at bottom of Notice) and we ask that you provide us with some additional information so that we can resolve the issue and fulfill your request. Please submit the additional information described in this Notice directly to MRO by mail, fax, or email (listed below). Once the issue is resolved, your request will be processed as quickly as possible.

MRO is processing your request in accordance with HIPAA regulations. Please notify the patient that the provision of treatment, payment, enrollment, or eligibility for benefits will not be conditioned on the elements of the authorization provided or your request for copies of the patient's records, unless permitted under 45 CFR 164.508(c)(2)(ii)(A)-(B).

Mailing Address:
MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

Email Address:
Requestinformation@mrocorp.com

Fax Number:
(610) 962-8421

Should you have any questions, please feel free to contact MRO directly regarding this request by dialing (610) 994-7500 Opt. 1 or by submitting an email to Requestinformation@mrocorp.com. To help us better assist you, please be sure to include your Request ID in the subject line of your email.

Thank you,
MRO

Patient Name: **JEFFREY BODIN**

Your Request Date:
Your Reference Number:
Date Received at Facility: 6/13/2018

Your request is being processed by MRO on behalf of the following facility:

Facility: **Children's Hospital of New Orleans**
200 Henry Clay
New Orleans, LA 70118

ISSUE LIST
Date Range Insufficient The date on the signed authorization does not reflect the entire date range for the date of service requested. Please mail or fax an updated authorization to the address or fax number listed above.

Authorization for Disclosure of Health Information

I hereby authorize Children's Hospital of New Orleans **to release medical information from the records of:**

(Name of Facility)

Patient Name: Jeffrey Bodin **D.O.B.:** 5/22/1997 **SS#:** XXX-XX-8926

Patient Street Address: 528 Bear Chase Dr

City: Mandeville **State:** LA **Zip Code:** 70471

Date(s) of Treatment Requested: 05/01/2018 – 06/31/2018
May 2018 to end of June 2018

Information to be disclosed (check all applicable items to be released):

- ☑ Medical Records
- ☑ Billing Records
- ☑ Discharge Summary
- ☑ Discharge Instructions
- ☑ History and Physical
- ☑ Consultations
- ☑ Operative Report
- ☑ ER Record
- ☑ X-Rays Reports
- ☑ Lab Reports
- ☑ EKG/ECG Tests
- ☑ Therapy Notes
- ☑ Progress Notes
- ☑ Medication Records
- ☑ HIV testing
- ☑ Nurse's Notes
- ☑ Commitment Papers
- ☑ Treatment Plans
- ☑ Doctor's Orders

☐ Other (please specify): _____

Purpose Or Need For The Disclosure Is:

☑ Continued Medical Care ☐ Insurance ☐ Legal ☑ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Recipient's Name: Jeffrey Bodin

Street Address: 528 Bear Chase Dr

City: Mandeville **State:** LA **Zip Code:** 70471

Phone #: 985-520-4713 **Fax #:** _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ **or upon the following event:** _____

(Date)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

Jeffrey Bodin
(Signature of Patient or Personal Representative)*

6/29/18
(Date of Signature)

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney
☐ Administrator ☐ Executor of Estate ☐ Next of Kin ☐ Beneficiary