Iron Mountain Records Management
1101 Enterprise Dr., Royersford PA 19468

Hello Patients of Luis F. Pineda, M.D., P.C.

We accept requests via mail, email, and fax.

**Please note: Patients should allow 30 days for records to be processed through our Release of Information team. We do not charge patients for copies of their records.

Luis F. Pineda, M.D., P.C.
Dr. Luis F. Pineda
1909 Laurel Road
Vestavia, AL 35216

Patients can mail, email, or fax requests to:
Iron Mountain Release of Information
11333 E. 53rd Ave.
Denver, CO 80239
DenverROI@ironmountain.com
Phone: 303-373-5764
Fax: 303-576-6874

HIPAA AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________________
Address: ______________________ **Social Security #:** ______________________
____
______________________ **Phone Number:** ______________________

Date(s) of Service for requested information: ______________________

I hereby authorize (name and address of hospital/doctor's office that created the medical records): Place name of facility/Doctor in this section

____
____
____

To release my medical records to (complete name, address and contact information):

____
____
____

Please release the following information in my medical record (check all that apply):

- ▢ History & Physical
- ▢ Consultation Report(s)
- ▢ Discharge Summary
- ▢ Operative Report(s)
- ▢ Emergency Room Record
- ▢ Laboratory Report(s)
- ▢ X-Ray/Imaging Report(s)
- ▢ Abstract or Summary
- ▢ Entire Medical Record
- ▢ Other: ______________________
____

Please release the following information in my medical record (check all that apply):

I ▢ do ▢ do not want HIV/AIDS information released under this authorization.

I ▢ do ▢ do not want mental health information released under this authorization.

I ▢ do ▢ do not want drug/alcohol abuse or treatment information released under this authorization.

I ▢ do ▢ do not want genetic testing information released under this authorization.

I ▢ do ▢ do not want sexually transmitted disease information released under this authorization.

The purpose for release of the above information is for:

▢ Continuation of Care ▢ Insurance ▢ Legal ▢ At my request (patient only) ▢ Other: ______________________

This authorization will expire within one (1) year. I understand that this authorization is voluntary and may be revoked by me at any time in writing by sending the written revocation to the facility in which I am requesting records, except to the extent that action has already been taken in reliance with this authorization. I understand that my hospital/doctor's office may or may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits upon my authorization of this disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

____
Signature of Patient or Patient's representative
(Personal & Legal Representative must include proof of status)

▢ Parent
▢ Personal Representative
▢ Legal Representative

____
Date

____
Witness

RETURN COMPLETED FORM TO: Iron Mountain

FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL BE RETURNED

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