CrossBorder Medical Records

MEDICAL RECORDS AUTHORIZATION / RELEASE OF INFORMATION (ROI)

Authorization for CrossBorder Medical Records to assist with requesting medical records from a healthcare provider or facility in Mexico. Important: This form authorizes release of the patient's records to the extent permitted by the healthcare provider/facility and applicable law. CrossBorder Medical Records is a medical-records retrieval assistance service and is not a healthcare provider and does not provide medical advice.

1. PATIENT INFORMATION

(Print) Patient full legal name: _____

Date of birth: _____ Former name(s), if applicable: _____

Patient current address: _____

Phone: _____ Email: _____

2. AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Complete this section if the person signing is not the patient. Documentation of legal authority may be requested.

Representative full name: _____

Relationship to patient: _____ Phone: _____

Email: _____

3. HEALTHCARE PROVIDER / FACILITY IN MEXICO

Provider/facility name: _____

City / State, Mexico: _____

Department / physician, if known: _____

Approximate dates of treatment: _____

4. RECORDS AUTHORIZED FOR RELEASE

I authorize the healthcare provider/facility identified above to release copies of the following records, if maintained and releasable:

General and Clinical Records ☐ Complete medical record or chart ☐ Office or clinic notes ☐ Hospital records ☐ Discharge summaries ☐ Emergency department records	**Tests, Imaging, and Treatment Records** ☐ Laboratory and pathology results ☐ Imaging reports and, if available and releasable, imaging files ☐ Medication and prescription records ☐ Surgical and procedure records **Administrative and Other Records** ☐ Medical Records Authorization / Release of Information (ROI) ☐ Billing or itemized statements ☐ Other records (describe): _____

Other:

5. PURPOSE OF REQUEST

Purpose of obtaining records (check all that apply):

☐ Personal records ☐ Continuity of care ☐ Insurance or administrative purpose	☐ Legal or administrative request ☐ Other: _____

Other:

6. RELEASE TO / AUTHORIZED RECIPIENT

I authorize the provider/facility to release the requested records to: Authorized recipient:

Business email: request@crossbordermedicalrecord.com

Authorized recipient: CrossBorder Medical Records, as the patient's authorized retrieval assistance service, and/or the patient or another recipient designated by the patient.

Patient's preferred delivery
☐ Electronic ☐ Secure electronic method ☐ Other: _____

7. AUTHORIZATION AND ACKNOWLEDGMENTS

1. I understand that the healthcare provider or facility ultimately determines whether records can be released and what records can be released.

2. I understand that CrossBorder Medical Records does not guarantee that records will be available, complete, released, or obtained within a particular timeframe.

3. I authorize CrossBorder Medical Records to communicate with the identified healthcare provider/facility as reasonably necessary to assist with this records request.

4. I understand that additional identification, authorization, fees, translations, or documentation may be requested by the healthcare provider/facility before records are released.

5. I understand that CrossBorder Medical Records is not a healthcare provider and does not provide medical advice, diagnosis, treatment, or legal advice.

6. I understand that I should review the provider/facility's requirements and any applicable rights or restrictions concerning the release of my records.

7. I understand that this authorization may be subject to applicable Mexican and/or U.S. privacy and records-release requirements, and the provider/facility may apply its own release procedures.

8. EXPIRATION / REVOCATION

Unless a different expiration date or event is required by the healthcare provider/facility or applicable law, I intend this authorization to remain effective until the records request described above has been

completed. I understand that I may revoke this authorization in writing, subject to actions already taken in reliance on the authorization and any applicable law or provider requirements.

Expiration date/event (optional): _____

9. SIGNATURE

By signing below, I confirm that I have read and understood this authorization and that the information provided is accurate to the best of my knowledge.

Patient / authorized representative signature: _____

Printed name: _____Date:_____

Relationship to patient (if not patient): _____

10. CONTACT / SUBMISSION

- CrossBorder Medical Records
- Medical Records Retrieval from Mexico
- **Email**: request@crossbordermedicalrecord.com
- **Website:** crossbordermedicalrecords.com

Submission note: Use the secure submission method provided by CrossBorder Medical Records. Do not email medical records or other sensitive health information through an unsecured method unless you have been instructed that the method is appropriate and secure. This form is intended as a general authorization template and does not replace legal advice or a provider/facility-specific authorization form. A healthcare provider or facility may require its own form or additional documentation