



# CHARTFAST

## PATIENT RECORD REQUEST

The ChartFast platform allows you to manage requests for your medical records with the click of a button!

To make a request for new records:

1. Go to **www.chartfast.com** and click the green **"Request Your Records"** button, which will take you into the ChartFast platform login screen



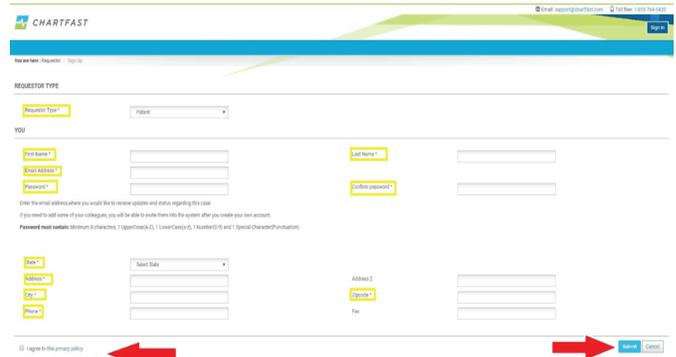
2. Under **"New Requestor"** click **"Register"**



3. If you are a patient requesting records for yourself or to send to another physician choose **"Patient"** from the dropdown box



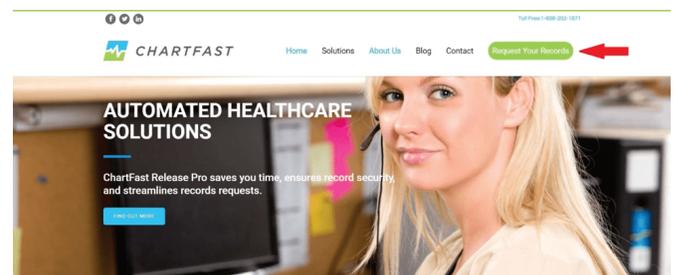
4. Fill out all information with a **red asterisk \***, be sure to check the boxes at the bottom left agreeing to privacy policy and terms and conditions then click the blue **"Submit"** button.



You will receive an email to confirm your account (be sure to check your Spam/junk folder if you do not see the email). If you do not receive the email please reach out to ChartFast at **678.829.4700**

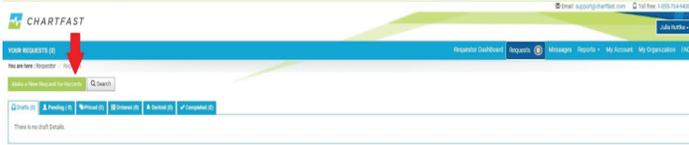
Once confirmed go to **www.chartfast.com** to request your medical records.

Click the green **"RequestYourRecords"** button to login to the ChartFast platform



**Sign in** with the user name and password that you created.

Inside the application click the green **“Make a New Request for Records”** button



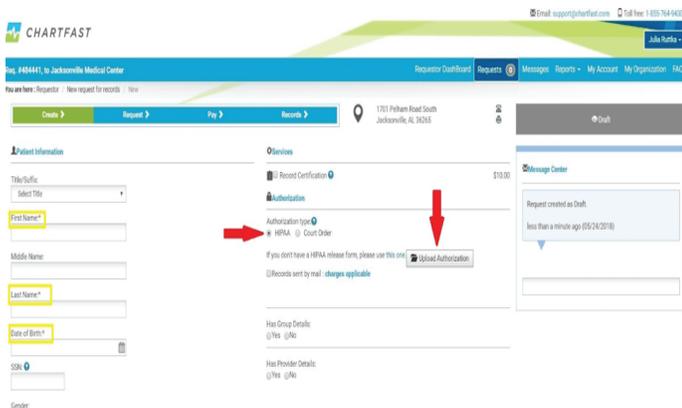
Click the drop down boxes and select the following;

- State – Texas**
- City – Where clinic located**
- Custodian/Facility Name – HeartPlace**

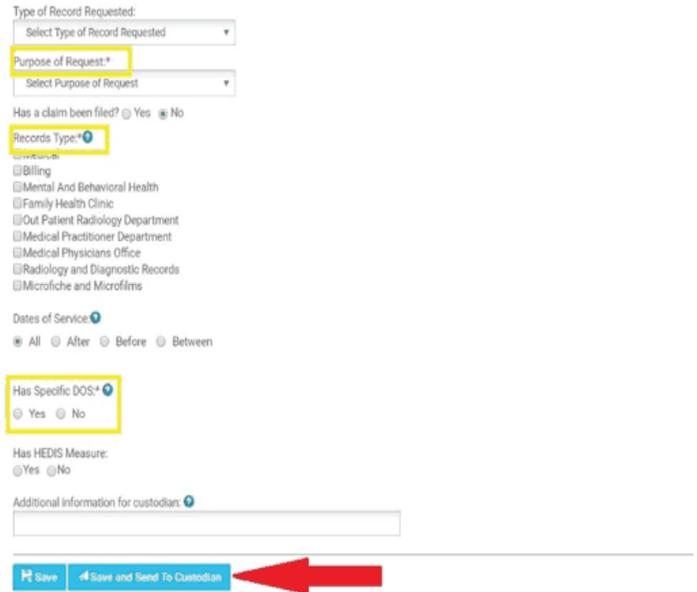


Fill out all information with a **red asterisk \***. You will need to upload an authorization form or letter stating you would like your records.

Check the **“HIPAA”** button on Authorization type, then click the **“Upload Authorization”** button to upload your saved authorization/letter.



Once you have filled out all necessary information (all fields with a **red asterisk \*** and uploaded your authorization letter) click the blue **“Save and Send to Custodian”** button at the bottom. Make certain that you utilize the following purpose of request from the drop down selection **“Patient - Patient Portal”**.



ChartFast will receive notification and begin processing your request.

Once completed, you will receive an email to login and retrieve and/or pay for the records (should there be a charge associated with the type of request you are making.)

If you have any question about this process, please reach out to us at **678.829.4700**

**If you have any questions about this process, call 678.829.4700 or send an email to roicustomerservice@chartfast.com**



**AUTHORIZATION FOR RELEASE OF INFORMATION FROM HEARTPLACE**

1. I hereby authorize HeartPlace to release and transfer to:

\_\_\_\_\_  
(Doctor, Hospital, Attorney, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State

\_\_\_\_\_  
Zip Code

the following information from its records on :

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Social Security Number

**SPECIFY INFORMATION:**

2. The above information is released for the following purpose and that purpose only. **Other uses are prohibited.**

\_\_\_\_\_  
3. I understand that the specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data.

4. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace took, including any uses or disclosures of my Protected Health Information made by HeartPlace, before it received the revocation of this Authorization.

5. I understand that if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

6. I understand that I have a right to inspect and copy my own Protected Health Information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

7. I authorize faxing the information to be disclosed to the requesting party.  Yes  No

8. I have read and understand this consent and I have signed it voluntarily and of my own free will.

9. This authorization will expire ninety (90) days from the date of signature.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Specify Relationship (legal & authorization where applicable) Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**PROHIBITION ON REDISCLOSURE: The following information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit the redisclosure of the information without the written consent of the person to whom it pertains unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.**

I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by HeartPlace to provide the copies requested.