

Authorization For Use or Disclosure of Medical Record Information Georgetown Medical Clinic



GEORGETOWN MEDICAL CLINIC
SPECIALISTS IN FAMILY MEDICINE



Patient Information

Patient Full Name: _____ Date of Birth: _____
 Patient Address: _____ Home Phone: _____
 City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Georgetown Medical Clinic to release my medical record information to:

Mail Copies To: _____ Discuss Medical Information With: _____

Name/Facility: _____ Attention: _____
 Address: _____ Phone: _____
 City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: Personal Continuing Care Insurance Legal
 Transfer Out/Reason _____ Other _____

Information to be Released

Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics) Please provide *only* the following records:
 _____ Progress Notes/Consults _____ Labs _____ Radiology
 _____ Pathology Dates of Service: _____

Please provide my entire medical record for dates:
 From _____ To _____

* See Fee Explanation Letter (attached) for information regarding costs for record production

Comments

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial each line below to confirm your choices

- | | | |
|-------------------------------|--|-------|
| I <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want *Psychiatric Treatment Notes released | _____ |
| I <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Mental Health released | _____ |
| I <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *HIV Tests & Related Information released | _____ |
| I <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Alcohol and/or Substance Abuse released | _____ |
| I <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about _____ released | _____ |

Other sensitive information?



Please confirm that you have put a checkmark and initialed ALL the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here

Date Here

Patient's Signature

Date*

Parent/Legally Recognized Representative Signature**

Date**

Witness

Date

Know Your Privacy Rights
Refer to the HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise: You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that Georgetown Medical Clinic has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following:

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Georgetown Medical Clinic will not condition treatment on payment of the provision of this Authorization.



Release of Information Fee Explanation

Georgetown Medical Clinic

3201 S Austin Ave # 210

Georgetown, TX 78626

Dear Patient:

As you can hopefully understand, the cost for the reproduction of medical records is quite extensive. In addition, we are bound by HIPAA (Federal Privacy Act) to track and report each request.

BACTES is Georgetown Medical Clinic’s medical records Release of Information provider. Texas state statute allows for the following fees for the copying and releasing of medical records in the case of a patient transfer:

- First 20 pages: \$25.00
- Per page after first 20 pages: \$.50 each page
- Plus any postage costs.

Georgetown Medical Clinic is “capping the fee at \$25 for a two-year abstract of your medical record including up to five years of diagnostics regardless of page count.”

If you require your entire record the fee will be according to Texas state statute.

Please fill out the “Authorization for use or Disclosure of Protected Health Information” form completely. For expedited processing, mail or deliver the completed form along with payment of \$25.00 to:

Georgetown Medical Clinic
3201 S Austin Ave # 210
Austin, TX 78626

If you have requested a 2 year abstract, your record will be sent within 5 days of receipt of the authorization and \$25.00 payment. If you want your complete record, you will be contacted regarding the additional fees per Texas statute within 5 days of receipt of the authorization and \$25.00 check made payable to Bactes

If you submit your request without payment, an invoice will be sent within 5 days of receipt.

This fee can be remitted by Check or Credit Card. If paid by Credit Card, we will need the following information. **NOTE: We accept VISA, Mastercard and American Express ONLY:**

Card Holder Name: _____	Exp Date: _____
Card Number: _____	(*)Security Code: _____
Zip Code of Cardholder: _____	Signature: _____

(* Security Code is the three number code on the back of your credit card (listed after the CC number).

Your request will be fulfilled upon payment in any of the above mentioned means. Should you have any questions regarding the fee, please contact Bactes (our service) at 512-410-0674.

Thank you again for your confidence in Georgetown Medical Clinic.