SOUTHWEST JOINT REPLACEMENT & SPORTS MEDICINE CENTER

BACTES a sharecare company

Disclosure Process and Fee Explanation Letter
TX22014

Dear Patient:

As a patient, you have a right to copies of your medical information. In addition, medical records are legal documents that must be maintained by Southwest Joint Replacement and Sports Medicine Center.

Under federal and state law, Southwest Joint Replacement & Sports Medicine Center or its medical records Release of Information provider, BACTES, is allowed to recover certain costs related to making copies of your medical records available to you. The fee we charge is cost-based to include labor and materials as defined by HIPAA and highlighted by the Omnibus Final Rule.

BACTES will charge a cost-based fee up to a maximum of $25.00 for a two-year abstract of your medical record along with up to five years of diagnostics regardless of page count. If you are seeking a copy of your entire medical record, the total cost-based fee could be significantly higher based on the page count of your record.

Please fill out the attached authorization form completely and submit with "Attention to Medical Records".

Request by Fax: (972) 566-3556

Request by Mail: Southwest Joint Replacement & Sports Medicine Center
7777 Forest Lane, Suite C-300G
Dallas, TX 75230

An invoice will be sent within 5-7 days of receipt. This fee can be remitted by Check or Credit Card.

Pay by Phone: (512) 596-0292

Pay by Mail: BACTES Imaging Solutions
9300 Jollyville Rd., Suite 206
Austin, TX 78759

Your request will be fulfilled upon payment. Should you have any questions regarding this fee, please contact BACTES at (512) 596-0292.

Thank you again for your confidence in Southwest Joint Replacement & Sports Medicine Center.

SOUTHWEST JOINT REPLACEMENT & SPORTS MEDICINE CENTER

Authorization For Use or Disclosure of Medical Record Information

BACTES a sharecare company

TX22014

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Southwest Joint Replacement & Sports Medicine Center 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 (*Explain*) ○Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: 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 federal and/or state privacy laws. Southwest Joint Replacement & Sports Medicine Center will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

○ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

○ Please provide my entire medical record for dates: From_____To_____

○ Please provide my entire billing record for dates: From_____To_____

○ Please provide *only* the following records within the date range listed below:
___ Progress Notes/Consults ___ Labs ___ Radiology
___ Pathology ___ Billing ___ Other (*Explain Below*)
From _____ To _____

Comments/ Authorization Specifications: _____

NOTICE: This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Southwest Joint Replacement & Sports Medicine Center, 7777 Forest Lane, Suite C-300G, Dallas, TX 75230, except to the extent that action has already been completed.

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 ☐ **DO** ☐ **DO NOT** want ***Psychotherapy Notes** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

STOP AND REVIEW: 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.

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It pertains or as otherwise permitted by 42 CFR Part 2.

Sign Here _____ Date Here _____

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

Description and Proof of Authority to Act on Patient's Behalf

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

Document Updated: 6/3/2016