Authorization For Use or Disclosure of Medical Record Information

Texas Heart & Vascular

TX170

Patient Information

Patient Full Name: ______________________________ Date of Birth: ____________________

Patient Address: ______________________________ Home Phone: ____________________

City: ______________ State ________ Zip: ____________ Work Phone: ____________________

Release Information To

I hereby authorize Texas Heart & Vascular 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 my entire medical record for dates:
From________________ To__________________

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

○ Please provide *only* the following records:
____ Progress Notes/Consults ____ Labs ____ Radiology
____ Pathology Dates of Service: ____________________

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 ☐ **DO** ☐ **DO NOT** want ***Psychiatric Treatment 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 __________

I ☐ **DO** ☐ **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 infomation 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 Texas Heart & Vascular 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. Texas Heart & Vascular will not condition treatment on payment of the provision of this Authorization.

Rev. 11/10

Release of Information Fee Explanation
Texas Heart & Vascular

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 Texas Heart and Vascular'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.

Texas Heart & Vascular 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, FAX the completed form to:

FAX : (512) 623-5399

Or Mail to:

Texas Heart & Vascular
4316 James Casey St.
Buildings A & C
Austin, TX 78745

An invoice will be sent within 5 days of receipt. This fee can be remitted by Check or Credit Card. Call with payment information or mail check to:

Bactes Imaging Solutions
4515 Seton Center Parkway
Austin, TX 78759
512-338-8402

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 512-338-8402.

Thank you again for your confidence in Texas Heart & Vascular.