GEORGETOWN MEDICAL CLINIC
SPECIALISTS IN FAMILY MEDICINE

Authorization For Use or Disclosure of Medical Record Information
GEORGETOWN MEDICAL CLINIC

B·A·C·T·E·S
PEOPLE • PROCESS • TECHNOLOGY

TX128

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_____

Comments

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

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?

STOP 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 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.

Rev. 11/10

Disclosure Process and Fee Explanation Letter
Georgetown Medical Clinic
TX128

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 Georgetown Medical Clinic. To assure we are doing everything we can to comply with HIPAA rules and protect the protect the privacy of our patients, we have partnered with BACTES, a national Release of Information provider, to assist us with this process.

Under federal and state law, 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, materials and postage as defined by HIPAA and highlighted by the Omnibus Final Rule. How the record is stored and delivered are variable factors affecting the fee.

To minimize this fee, we encourage you to limit your request to just the records that you truly need. *Note that on the attached authorization form, there is an option to select a 2-year abstract plus 5 years of labs, radiology, and diagnostics*. For many patients, this option is sufficient for their purposes and keeps their bill lower than it otherwise would be.

Please fill out the attached authorization form completely and submit via fax or mail.

512-930-4946
Request by Fax: **512-763-4077**

Request by Mail: Georgetown Medical Clinic
3201 S Austin Ave, Ste 210
Georgetown, TX 78626

Please note that the BACTES quality control process does extend the turn-around-time for your request to be fulfilled. However, you can expect that an invoice will be mailed to the address on your request within 5-7 business days. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by Check or Credit Card.

Pay by Phone: (800) 560-3800
Press #2 for Customer Service

Pay by Mail: BACTES Imaging Solutions
11130 Jollyville Rd., Suite 303
Austin, TX 78759

Pay Online http://www.bactes.com/
Click on Pay Online - Top left selection - https://payment.bactes.com/Payments/
Enter your email address for Receipt – Invoice # - Amount of Invoice

Your request will be fulfilled upon payment. For questions, please contact BACTES at **(800) 560-3800** and press 2 for BACTES Customer Service.

Thank you again for your confidence Georgetown Medical Clinic.