Authorization For Use or Disclosure of Medical Record Information
Austin Gynecology Associates, PA

TX161

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

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

Release Information To

I hereby authorize **Austin Gynecology Associates, PA** 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/Mental Health Notes** released _____

I ☐ DO ☐ **DO NOT** want information about ***Genetic testing** 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 **Sexual assault/abuse** 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 Austin Gynecology Associates, PA 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. Austin Gynecology Associates, PA will not condition treatment on payment of the provision of this Authorization.

Release of Information Fee Explanation
Austin Gynecology Associates, PA

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 Austin Gynecology Associates'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.	

Austin Gynecology Associates 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 authorization form to:

Release of Information
Austin Gynecology Associates- TX161 FAX 512-478-4366
1015 E. 32nd, Ste 216
Austin, TX 78705

An invoice will be sent to you upon receipt of your authorization. This fee can be remitted by Check or Credit Card. ***NOTE: We accept VISA, MasterCard and American Express ONLY.*** Your request will be fulfilled upon payment in any of the above mentioned means. You may mail a check (made payable to Bactes) to the following address or call with credit card information:

Bactes
4515 Seton Center Parkway, Ste 150
Austin, TX 78759
512-338-8402

Thank you again for your confidence in Austin Gynecology Associates, PA.