

TX166

**Patient Information**

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

**Release Information To**

I hereby authorize Northeast Orthopaedics & Sports Medicine, LLP 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?



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 Northeast Orthopaedics & Sports Medicine 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. Northeast Orthopaedics & Sports Medicine will not condition treatment on payment of the provision of this Authorization.



## Release of Information Fee Explanation Northeast Orthopaedics & Sports Medicine, LLP

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 Northeast Orthopaedics & Sports Medicine'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.

*Northeast Orthopaedics & Sports Medicine 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 : (210) 477-5152

Or Mail to:

Northeast Orthopaedics & Sports Medicine  
12709 Toepperwein Road Suite 101  
San Antonio, TX 78233

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, Suite 150  
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 Northeast Orthopaedics & Sports Medicine.