



Disclosure Process and Fee Explanation Letter Austin Area Obstetrics, Gynecology & Fertility

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 Austin Area OB/GYN. To assure we are doing everything we can to comply with HIPAA rules, 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.

Request by Fax: 512-450-1146

Request by Mail: Austin Area OB/GYN

12200 Renfert Way, Suite 100

Austin, TX 78758

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

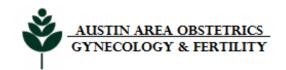
Pay Online http://www.bactes.com/

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 in Austin Area OB/GYN.



AUTHORIZATION FOR RELEASE OF INFORMATION

Complete medical records. (Initial and date beRecords of care from to	ox below if HIV/AIDS test results are to be included.)
Other (Please specify)	only.
Confer with another person orally about information in my record. Specify person under "TO". HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial:	
for release of medical records include "the reason: Change of Physician	s or purposes for the release.") Workers' Compensation or Disability Claim
Patient Moving	s or purposes for the release.") Workers' Compensation or Disability Claim Attorney/Legal
Application for Insurance Coverage	Other:
Consultation with another physician for (con	ndition)
Records Requested FROM:	Send Records TO:
Physician's Name	Physician's Name
Address	Address
City/State/Zip	City/State/Zip
(FAX including Area Code) Phone Number	(FAX including Area Code) Phone Number
records. A fee maybe charged according to TMA gu	of to exceed 15 days) may be required to retrieve my aidelines. The fee will be \$25 for the first 1-20 pages. The bu would like your records mailed to you, you will be yable in advance.
I would like to:Pick up records from the offi Have records faxed	ceHave records mailedHave records stored electronically
records. I understand that reports may include in communicable disease treatment. I understand t except to the extent that action has already bee	that I may revoke this consent in writing at any time on taken in reliance on it. I understand that the any when the law provides my insurer with the right to this consent shall be considered valid. This
Patient's Full Name (Please Print):	
Date of Birth: Social Security #	Year last seen:
Any other name(s) under which your records may be filed:	
Patient's Signature:	Date:
	n patient's behalf. If not patient, state relationship to
patient and reason patient unable to sign.)	