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.

AUSTIN AREA OBSTETRICS
GYNECOLOGY & FERTILITY

AUTHORIZATION FOR RELEASE OF INFORMATION

Records requested:

____Complete medical records. (Initial and date box below if HIV/AIDS test results are to be included.)
____Records of care from _____ to _____ only.
____Other (Please specify) _____

____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:_____ Date:_____

Reason for Release: (Article 4495 b, Sec. 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reasons or purposes for the release.")

_____ Change of Physician
_____ Patient Moving
_____ Application for Insurance Coverage
_____ Consultation with another physician for (condition) _____
_____ Workers' Compensation or _____ Disability Claim
_____ Attorney/Legal
_____ Other: _____

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

I understand that a reasonable amount of time (not to exceed 15 days) may be required to retrieve my records. A fee maybe charged according to TMA guidelines. The fee will be $25 for the first 1-20 pages. The fee will be 50 cents for each page thereafter. If you would like your records mailed to you, you will be charged the actual postage fee. All fees will be payable in advance.

I would like to: _____Pick up records from the office _____Have records mailed
_____Have records faxed _____Have records stored electronically

I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. I understand that the revocation will NOT apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

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:_____

(Patient or person legally authorized to consent on patient's behalf. If not patient, state relationship to patient and reason patient unable to sign.)