Authorization For Use or Disclosure of Medical Record Information
Westlake Family Practice

Westlake Family Practice

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

TX016

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

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

Release Information To

I hereby authorize **Westlake Family Practice** 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 Westlake Family Practice 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. Westlake Family Practice will not condition treatment on payment of the provision of this Authorization.

Release of Information Fee Explanation
Westlake Family Practice

5656 Bee Caves Rd., Suite E-200
Austin, TX 78746

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 Westlake Family Practice'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.	

Westlake Family Practice 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 form along with payment of $25.00 to:

Release of Information - Westlake Family Practice TX016
5656 Bee Caves Rd., Suite E-200
Austin, TX 78746

If you have requested a 2 year abstract, your record will be sent within 5 days of receipt of the authorization and $25.00 payment. If you want your complete record, you will be contacted regarding the additional fees per Texas statute within 5 days of receipt of the authorization and $25.00 check made payable to Bactes.

If you submit your request without payment, an invoice will be sent within 5 days of receipt.

This fee can be remitted by Check or Credit Card. If paid by Credit Card, we will need the following information.
NOTE: We accept VISA, Mastercard and American Express ONLY:

Patient's Name: _____ Card holder's phone #: _____

Card Number: _____ Exp. Date:_____

(*) Security Code:_____Amount of payment (**):_____

(**)Please check one - Requested information: ☐ *$25 -2yr abstract or* ☐ *Full Record _____*
(*) Security Code is the three number code on the back of your credit card (listed after the CC number). TX016

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 Westlake Family Practice.