St David's | South Austin Trauma Surgeons
St. David's South Austin Medical Center

Authorization For Use or Disclosure of Medical Record Information
South Austin Trauma Surgeons

BACTES™ a sharecare company

TX10901

Patient Information

Patient Full Name: ______________________ Date of Birth: ______________

Patient Address: ______________________ Home Phone: ______________

City: ____________ State ______ Zip: ________ Work Phone: ______________

Release Information To

I hereby authorize South Austin Trauma Surgeons 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 (*Explain*) ◯Other (*Explain*)

Comments/ Authorization Specifications: ______________________

NOTICE: 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 federal and/or state privacy laws. South Austin Trauma Surgeons will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

◯ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

◯ Please provide my entire medical record for dates: From____________To____________

◯ Please provide my entire billing record for dates: From____________To____________

◯ Please provide *only* the following records within the date range listed below:
___ Progress Notes/Consults ___ Labs ___ Radiology Reports
___ Pathology ___ Billing ___ Other (*Explain Below*)

From ______________ To ______________

Comments/ Authorization Specifications: ______________________

NOTICE: This Authorization is valid for 180 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at The Center for Hip and Knee Replacement, except to the extent that The South Austin Trauma Surgeons has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

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 ***Psychotherapy 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 ________

STOP AND REVIEW: 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.

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It pertains or as otherwise permitted by 42 CFR Part 2.

Sign Here Date Here

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

Description and Proof of Authority to Act on Patient's Behalf

Know Your Privacy Rights
Refer to the HIPAA **"PRIVACY NOTICE"**

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Disclosure Process and Fee Explanation Letter
South Austin Trauma Surgeons
TX10901

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 South Austin Trauma Surgeons.

Under federal and state law, South Austin Trauma Surgeons or its medical records Release of Information provider, 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 and materials as defined by HIPAA and highlighted by the Omnibus Final Rule.

South Austin Trauma Surgeons and BACTES will charge a cost-based fee up to a maximum of $25.00 for a two-year abstract of your medical record along with up to five years of diagnostics regardless of page count. If you are seeking a copy of your entire medical record, the total cost-based fee could be significantly higher based on the page count of your record.

Please fill out the attached authorization form completely and submit via fax or mail.

Request by Fax: (737) 202-3872

Request by Mail: South Austin Trauma Surgeons
4007 James Casey St, Ste B140
Austin, TX 78745

An invoice will be sent within 5-7 days of receipt. This fee can be remitted by Check or Credit Card.

Pay by Phone: (512) 596-0292

Pay by Mail: BACTES Imaging Solutions
9300 Jollyville Rd., Suite 206
Austin, TX 78759

Your request will be fulfilled upon payment. For questions, please contact BACTES at 512-596-0292.

Thank you again for your confidence in South Austin Trauma Surgeons.