AUSTIN REGIONAL CLINIC

Authorization for Use or Disclosure of Medical Record Information
Austin Regional Clinic

ARC MRN

ARC Location

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

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

Release Information To:

I hereby Authorize Austin Regional Clinic (ARC) to release my medical record information to:

☐ Mail Copies To: ☐ Hold for Patient Pickup ☐ Discuss Medical Information with:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ○ Personal ○ Continuing Care (second opinion or refer to specialist) ○ Insurance ○ Legal
○ Transfer Out (Reason? _____) ○ Other _____

Information to be Released:

○ Please provide a 2 year abstract (includes 5 years of diagnostics)
- Copy fee capped at $25.00 for a 2 year abstract

○ Other – Please be specific, include dates and providers under comments. Note: You will be invoiced at the allowable TX Statute Copy Fee: $25.00 for the first 20 pages; $0.50 per page over 20 pages, plus postage (Postage will not exceed $15.00)

Comments

Authorization to Release Protected Information

*__Required__ – Please complete the check boxes indicating how protected information should be handled

Release Records? Check One — Initial each line below to confirm your choices

I ☐ **DO** ☐ **DO NOT** want my **Entire Record** released. _____

I ☐ **DO** ☐ **DO NOT** want information about **Mental Health Treatment** (other than Psychotherapy Notes) released. _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests & Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Genetic Testing Information** released. _____

I ☐ **DO** ☐ **DO NOT** want information about *** Hepatitis C 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?

I ☐ **DO** ☐ **DO NOT** want this information to be disclosed electronically. *ARC reserves the right to disclose information electronically for treatment, payment, or healthcare operations, unless otherwise required by law.* _____

STOP Please confirm that you have put a checkmark and initialed **ALL** the protected information categories above regardless of 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.

I specifically authorize ARC to disclose my Protected Health Information as described on this form to the recipients listed above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth above.

I understand ARC is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or healthcare operations. I have read the authorization and understand what information will be used or disclosed, who may use and disclose this information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

Sign Here _____ Date Here _____

Patient's Signature — Date*

_____ _____

Parent/Legally Recognized Representative Signature** — Date**

_____ _____

Witness — Date

Know your Privacy Rights
Refer to HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for 90 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, except to the extent that ARC 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 released pursuant to the Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.

[1]**CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Release of Information Fee Explanation
Austin Regional Clinic

Dear Patient,

HealthPort is the company that Austin Regional Clinic contracts with for release of medical records. HealthPort's fees follow Texas state statute for the copying and releasing of medical records:

If you require paper copies, the fees are as follows:
Pages 1-15: Free
Pages 16-20: $1.00 per page
Pages 21 and up: $0.50 per page
Plus any postage costs (The postage will not exceed $15.00)

If you wish to receive your records electronically, the fees are as follows:
First 500 pages: not to exceed $25.00
More than 500 pages: not to exceed $50.00

Austin Regional clinic 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 HealthPort charges 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, please mail, deliver, or fax the completed form to:

HealthPort – Release of Information
6937 N IH 35, Ste 500
Austin, TX 78752
Fax: 512-380-9833

An invoice will be sent within 5 days of receipt. This fee can be remitted by Check or Credit Card. Payment may be mailed to the address above or provided over the phone:

HealthPort – Release of Information
Phone: 770-810-8908

Your request will be fulfilled upon payment in any of the above mentioned means. Should you have any questions regarding the fee, please contact HealthPort at 770-810-8908.

Thank you for your confidence in Austin Regional Clinic.