Release of Information Fee Explanation

Dear Patient:

It is the policy of Seven Oaks Women's Center to send up to **one year** of the patient's Medical Record. This includes the patient history, radiology, operative reports.

Upon your review of the patient's medical documentation should there be a need for additional medical history please specify in your request the information required.

Texas HB 300 requires the transfer of PHI to be in electronic format, unless the patient agrees to receive the medical record as another format, preferably by fax.

The Texas Medical Board allows for the following fees for the copying and releasing of medical records in the case of a patient transfer:

Dr. to Dr. NO CHARGE
Patient, Insurance Companies, and 3rd party request will be subject to the following fees:
First 20 pages: $25.00
Per page after first 20 pages: $.50 each page

Please fill out the "Authorization for use or Release of Protected Health Information" form completely. For expedited processing FAX or mail the completed form to:

Seven Oaks Women's Center
8122 Datapoint Dr, STE 1150
San Antonio, TX 78229
FAX: 210-616-9300

Your request will be fulfilled within 15 business days upon receipt of the medical release form or 15 days upon receipt of payment in any of the above mentioned means.

Thank you,
Medical Records Dept.
210-692-9500 ext. 249

Seven Oaks Women's Center

7707 Ewing Halsell, Suite 213
San Antonio, TX 78229
Office: 210-692-9500 Fax: 210-616-9300

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print)				Date of Birth	
Street Address	City	State	Zip	Phone Number	Cell Number
Maiden name or other name used for records				Practice Use:	Medical Record #

I hereby authorize: (Please print) **(*Information Required)**	***To release to: (Please Print)*** **(*Information Required)**
****Name:***	****Name:***
****Address:***	****Address:***
****Phone#:*** ****Fax:***	****Phone#:*** ****Fax:***

My last year's worth of records to include:

☐ Operative Reports ☐ History & Physical ☐ Radiology Reports
☐ Discharge Summary ☐Other (*Specify*):
_____
_____
_____
_____

Medical Records will be faxed or mailed on Disc depending on page count.

I ☐**do** ☐ **do not** (check applicable box) authorize this information to be faxed. If YES, fax number:

Covering the period from _____ to _____.

_____ **(Initial)** I understand that this authorization will include information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
Psychiatric care
Treatment for alcohol and/or drug abuse
Genetic Testing

If any, except as specifically stated here: _____.

This information is to be disclosed for the purpose of: _____.

The date, extent or condition upon which this authorization expires is ___/___/___ not to exceed 24 months (except for research purposes, state "NONE" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization.

I understand and agree to pay a reasonable fee to cover the cost of transfer of PHI. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other that **Seven Oaks Women's Center** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **Seven Oaks Women's Center** concerning me, including incorporated records. I acknowledge that **Seven Oaks Women's Center** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Seven Oaks Women's Center** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **Seven Oaks Women's Center** is not responsible for completeness, legibility, or omissions used by the copying of any medical records from another institution.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative: _____
Relationship to patient: _____

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this shall be fined or imprisoned.