HMC
HOUSTON | SUGAR LAND

Authorization For Use or Disclosure of Medical Record Information
Hillcroft Medical Clinic

sharecare | HEALTH DATA SERVICES

TX334

Patient Information

Patient Full Name: _____ Date of Birth:

Patient Address: _____ Home Phone:

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

Release Information To

I hereby authorize Hillcroft Medical Clinic to release my medical record information to: _____

☐ Mail Copies To: ☐ Discuss Medical Information With: Name/Facility:

_____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose: ○ Personal ○ Continuing Care/ Referral ○ Insurance ○ Legal ○ Transfer (*Explain*) ○ Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: The information released 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 Hillcroft Medical Clinic 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 unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department Hillcroft Medical Clinic, except to the extent that Hillcroft Medical Clinic 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 below to confirm your choice***

I ☐ **DO** ☐ **DO NOT** want information about communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. _____

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed 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.

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 Rights
Refer to the HIPAA **"Notice of Privacy Practices"**

Document Updated: 11/9/2016

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Disclosure Process and Fee Explanation Letter

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 Hillcroft Medical Clinic To assure we are doing everything we can to comply with HIPAA rules and protect the privacy of our patients, we have partnered with Sharecare Health Data Services, a national Release of Information provider, to assist us with this process.

Under federal and state law, Sharecare Health Data Services 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.

Fax # 281-242-2697
Hillcroft Medical Clinic
1429 HWY. 6
Sugarland, TX 77478

Please note that the Sharecare Health Data Services 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.

Check Status 5-7 business days after submitting request:	https://recordstatus.sharecare.com/
Pay by Phone:	(800) 560-3800 Press #2 for Customer Service
Pay Online	http://hds.sharecare.com/ Click on Pay Online - Top left selection - https://payment.hds.sharecare.com/Payments/ Enter your email address for Receipt – Invoice # - Amount of Invoice

Your request will be fulfilled upon payment. For questions, please contact Sharecare Health Data Services at **(800) 560-3800** and press 2 for Sharecare Health Data Services Customer Service.

Thank you again for your confidence in Hillcroft Medical Clinic.