PEDIATRIC Urgent Care

Patient Authorization for Release of Health Records

1. I authorize _____to disclose information from the health records of:

_____ Account #: _____ Date of Birth: _____
(patient full name)

2. **The information is to be disclosed to**: _____

Address (sender/receiver if other than Little Spurs Pediatric Urgent Care):_____

City, State, Zip: _____

Contact Person: _____Phone:_____/Fax:_____

E-mail Address: _____-_____

I authorize this information to be disclosed in the following ways:

❑ Written/Photocopy/Paper ❑ Verbal ❑ Fax ❑ Electronic Mail *

Purpose of the disclosure: _____

3. **Dates of Treatment:** From: _____ To: _____

Specific reports to be disclosed:

❑ Progress Notes ❑ Laboratory Reports ❑ Operative Reports
❑ Discharge Summary ❑ Radiology Reports ❑ Consultation Reports
❑ X-ray films or other images ❑ Photographs/Videotapes ❑ Records from other facilities

❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)

❑Other(Specify):_____

I give specific authorization to disclose the following information:

❑ HIV test results ❑ Documentation of AIDS diagnosis
❑ Drug and alcohol abuse treatment records ❑ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Little Spurs Pediatric Urgent Care in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Information disclosed pursuant to the authorization may be subject to re-disclosure and may no longer be protected by the Privacy Rule.

Unless revoked earlier, this authorization expires in one year unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)

Note: Need to ensure separate E-mail Authorization Agreement is signed.
Note: Release of Psychotherapy notes requires a separate authorization.

14100 SAN PEDRO AVENUE, SUITE 608, SAN ANTONIO, TEXAS PHONE: (210) 543-7334 FAX: (210) 263-9998

LITTLE SPURS PEDIATRIC *Urgent Care*

Request for Protected Health Information (Medical Records)

Little Spurs Pediatric Urgent Care accepts requests for Protected Health Information (medical records). In order to process requests for medical records quickly and accurately, these guidelines are provided for your convenience. Please read carefully. Keep this for future reference.

Requests for Protected Health Information, or Medical Records, are processed in accordance with federal HIPAA and Texas State HB300 privacy laws. Please follow the steps listed below:

1. Complete, sign and date an "Patient Authorization for Release of Health Records". Be sure to complete **ALL** blank lines on the form. Please include a phone number where you can be reached. We will call you if we have questions and when the records are ready.
2. List the date(s) of service for which you are requesting. You may indicate all dates.
3. Check or specify exactly what information you need from the medical record.
4. There is a charge for medical records, payable in advance.
5. The more specific the information you provide regarding your information needs, the lower the charges will be for copying. For example: If you need notes for one visit date, do not request the entire medical record. You may request a summary of any or all the visit notes.
6. The law allows the records to be processed 15 days after the date of our receipt of the request. Normal processing time is much quicker.
7. In a few cases, a request is denied due to specific reasons or errors. Common errors include: An incomplete Authorization form (ALL blank lines must be completed), an unauthorized representative is requesting records, etc. We will contact you if your request is denied.
8. Once the request for medical records is processed and complete, the Company representative will contact you to discuss any fees, the method of payment and instructions for pick up. For an additional mailing fee, records can also be mailed.
9. The fee schedule is listed below. Fees are set by the Texas Administrative Code, Chapter 165, Title 22, Part 9. A provider's office is not required to permit copying until the fee is paid.

MEDICAL RECORDS COPY FEES

REQUESTOR	CHARGE
PHYSICIANS, HOSPITALS, AND TPO	NO CHARGE TO FAX
ALL OTHER REQUESTORS: PATIENTS, ATTORNEYS, OTHER ENTITIES FMLA FORMS:	1-20 PGS. $6.50 $0.50 CENTS PER PAGE FOR EVERY COPY THEREAFTER USPS MAIL FEES APPLY FOR MAILING RECORDS $25.00 Per Form
AFFIDAVIT: EACH	$15.00 PER FORM
NOTARY	$6.00 PER SIGNATURE
POSTAGE RESTRICTED RETURN RECEIPT	$25.00
CD - COPY OF X-RAY	$8.00 PER COPY
SOCIAL SECURITY BENEFITS	NO CHARGE IF WRITTEN PROOF IS PROVIDED FROM SOCIAL SECURITY ADMIN.

10. The Medical Records department representative can be reached Monday through Friday 9 AM to 4 PM. Please call 210-543-7334 and listen for the Medical Records prompt, or dial 0.
11. If no one answers, please leave a detailed message and we will return your call.
12. MEDICAL RECORDS MAY BE PICKED UP AT ANY LOCATION, INCLUDING THE CLINIC WHERE YOUR CHILD WAS SEEN. PICK UP HOURS ARE: MONDAY THRU FRIDAY 9AM-4PM. Please take this informational paper with you for future reference.

A VALID GOVERNMENT PICTURE I.D. IS REQUIRED TO VERIFY YOUR IDENTITY UPON RECORDS PICK UP.