AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Instructions to Obtain Copies of Medical Records

Thank you for allowing the Facey Medical Group the opportunity to be your healthcare provider. Please review the following guidelines and instructions to expedite your receipt of your medical records.

California law (AB610) allows the healthcare provider a 15-day turnaround time from the date a request is received, to process a patient's request for copies of their medical records. Facey's turn-around time is about 15 business days depending on the location of your medical records (off-site storage, off-site clinic locations, etc).

The growing number in Federal and State statutes regarding privacy and security of your personal health records has necessitated Facey to implement strict guidelines when releasing copies of your medical records. Due to the growing costs associated with these guidelines, including the labor to secure medical records from various sources, it is necessary that Facey charge a nominal fee to offset some of these increased operating costs. We have provided you with a Medical Record Request Packet (attached) and instructions to request copies of your medical records. In order to process your request, please complete and submit the following material to our **Release of Information** personnel.

- Consent To Release Medical Information Authorization form
- Medical Record Request Payment form with $15.00 prepayment
- Request for Radiology Films/CD (excluding mammography) with $18.00 payment

Please note the following:

- We **do not** accept cash. Only check, money order or credit card is acceptable payment.
- Incomplete or missing information on your Authorization may impact the turn around time of your request.
- If you are paying by **Credit Card** you can also fax it to (818) 743-5343 attention: Release of Information

You may mail (see address below) e-mail (roirequests@facey.com) or drop off your packet in person to the Facey Medical Record Release of Information Department at the address noted below or complete the packet and leave it at one of our convenient **Facey clinic locations**. We will forward your request to our **Release of Information Department.**

Drop Off Only
Facey Medical Group
Attn. **Release of Information Department**
11333 N. Sepulveda Blvd.
Mission Hills, CA 91345-1196

Mail Only
Facey Medical Group
Release Of Information
11165 Sepulveda Blvd.
Mission Hills, CA. 91345

Should you have any questions about the status of your records after submitting the attached information, please call Release of Information Department at 818-837-5668.

Thank you for allowing us to serve you. Facey Medical Group

DO NOT SCAN

Facey MEDICAL GROUP

EMRN:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Attention: Release of Information Department
Office (818) 837-5668 **Fax** (818) 743-5343
Drop Off Only 11333 N. Sepulveda Blvd
Mission Hills, CA. 91345

Type of access requested: (If selecting more than one (1) option, additional charges may apply)

☐Paper copy of records ☐CD Copy ☐Inspection of records (by appointment only - *allow 5 business days*)
☐ Transfer Request ☐ Radiology CD ☐ Radiology Films

I request access as the ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney
(Proof of legal documentation is required)

Name of Patient (***Please print clearly***)	AKA	Date of Birth
Address City State Zip Code		(_____) _____ Telephone

Please **SEND** medical information **TO**: (☐ *If same as above*)	Please **REQUEST** medical information **FROM:**
Name of Person or Entity to Receive Information	Name of Medical Office/Provider
Street Address	Street Address
City, State and Zip Code	City, State and Zip Code
Telephone	Telephone

Duration: This authorization will expire 12 months from the date signed.

Revocation Process: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Facey Medical Group.

Right to Copy: I have a right to receive a copy of the Authorization after I sign it.

Re-Disclosure Statement: I understand that once Facey Medical Group discloses my health information to the recipient, Facey Medical Group cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.

SPECIFY RECORDS TO BE RELEASED

(Check the box and initial which type of information is to be released)

- ☐ All General Medical Information (from _____to _____). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may included information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.
- ☐ Information regarding specific injury or treatment (from_____ to _____)
- ☐ Radiology (*check what is needed*): (from_____ to _____) ☐ Reports ☐CD *(CD Format requires 72 hours processing time)* ☐ Films ($18.00 per slide) Ultrasound X-Ray *(Excludes Mammography Images-Use Mammography Image form)*
- ☐ Laboratory results (from_____ to _____)
- ☐ Mental health Only (from_____ to _____) _____
  (Psychotherapy sessions) Signature of Patient or Patient's Representative
- ☐ Immunizations Only
- ☐ Other (Specify): _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Facey Medical Group to use or disclose my health information in the manner described above.

_____ _____ _____

Date Signature of Patient or Representative Indicate Relationship (if not signed by patient)

Your medical record request will be mailed to the address provided.

OFFICE USE ONLY

Request processed by: _____ /_____ Date: _____

Approved by(Please print and sign)

_____

_____

If denied state reason why:_____

_____/_____ Date:_____

Denied by (Please print and sign)

Bactes Use Only (Bactes copied date stamp) ⟶

Medical Record Payment Form

CA CIVIL CODE 123110: California Patient Access to Health Records. Inspection and copying; Paragraph (b) Additionally any patient or patient's representative shall be entitled to copies of all or any portion of the patients records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed ($.25) per page.

Date: _____ Medical Record #: _____

Patient Name: _____ Daytime contact #: _____

Payment Method (To Be Completed by Patient*) NO CASH ACCEPTED*

❒ Check (payable to: Bactes) ❒ Money Order ❒ Credit Card (MC, Visa, AMEX)

Check / Money Order #: _____

Credit Card Number: _____

Expiration Date: _____ **3 Digit Security Code:** _____

Name on Credit Card: _____

Signature of credit card holder: _____

Billing Address (on card): _____

Charges for the cost of reproduction of medical records for STANDARD *(up to 15 business days)* processing:

1 - 60 pages = $15.00 (payable at time of request)

61+ pages = $0.25 per page

For Office Use Only:

Total Page Count _____ less 60 pages = _____ remaining pages.

Remaining pages of _____ @ $0.25 per page = **Total amount due:** $_____

Date patient notified of charges: _____ Total pages copied: _____ Date Picked Up:_____

***Please note: If paying by credit card, your information will be shredded upon completion.**

DO NOT SCAN