Hill Country OB/GYN Associates

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Board Certified in Obstetrics & Gynecology

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 Hill Country OB/GYN Associates. 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.

Hill Country OB/GYN Associates
9805 Brodie Ln
Austin, TX 78748
Phone: (512) 462-1936 Fax: (833)448-3184

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

For questions or status inquiries, Contact Sharecare Customer Care:
Medical Records Requests: (800) 560-3800
FMLA/Short-Term Disability Forms: (866) 273-4039

Thank you again for your confidence in Hill Country OB/GYN Associates.

Hill Country OB/GYN Associates
for all phases of a woman's life

Authorization For Use of Disclosure of Medical Record Information

(512) 462-1936 | (833)448-3184 FAX

sharecare
(800) 560-3800
Press #2 for Customer Service

Patient Information

Patient Full Name: _____ Date of Birth: _____
Patient Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work: _____

Release Information To

I hereby authorize Hill Country OB/GYN Associates to release my medical record information to:

To: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____

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

Format: ___ Mail (Please include address above) ___ Electronic Email: _____

Comments/ Authorization Specifications: _____

NOTICE: The information released pursuant to this Authorization may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state Hill Country OB/GYN Associates 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 Hill Country OB/GYN Associates, except to the extent that Hill Country OB/GYN Associates has already completed action on it.

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:*

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.
Initial to confirm your choice: _____

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.
POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legally Recognized Representative Signature Date

_____ _____
Description and Proof of Authority to Act on Patient's Behalf Date

Know Your Rights Refer to the HIPAA "Notice of Privacy Practices"
Document Updated: 11/9/2016