# Disclosure Process and Fee Explanation Letter
# Grace Medical Center

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 Grace Medical Center. 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 (HDS), a national Release of Information provider, to assist us with this process. Under federal and state law, Sharecare HDS 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 to:

Grace Health System
2412 50th Street
Lubbock, TX 79412
FAX: 806-686-3354

Please note that the Sharecare HDS quality control process does extend the turn-around-time for your request to be fulfilled. However, you can expect that an invoice will be sent to the address on your request within 14 business days. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by Check, PayPal or Credit/Debit Card.

**Check Status 5-7 business days after submitting request:** https://recordstatus.sharecare.com/

**Pay Online**
https://hds.sharecare.com/
Click on Pay Online - Top right selection –
https://payment.bactes.com/Payments/
Enter your email address for Receipt – Invoice # - Amount of Invoice

**Pay by Phone:** (800) 560-3800
Press #2 for Customer Service

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

Thank you for your confidence in Grace Medical.

# Authorization For Use or Disclosure of Medical Record Information
# Grace Medical Center

GRACE HEALTH SYSTEM™

BACTES a sharecare company

TX230

## Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

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

## Release Information To

I hereby authorize Grace Medical Center to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○Personal ○Continuing Care ○Insurance ○Legal ○Transfer (*Explain*) ○Other (*Explain*)

*Comments/ Authorization Specifications:* _____

**NOTICE:** The information release 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 privacy laws. Grace Medical Center 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
___ Pathology ___ Billing ___ Other (*Explain Below*)
From _____ To _____

*Comments/ Authorization Specifications:* _____

**NOTICE:** This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Grace Medical Center, 2412 50th St, Lubbock, TX 79407, except to the extent that Grace Medical Center 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 each line below to confirm your choices*

I ☐ **DO** ☐ **DO NOT** want ***Psychotherapy Notes** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

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

**NOTICE TO RECIPIENT:** Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It

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 Privacy Rights**
Refer to the HIPAA **"PRIVACY NOTICE"**

*Document Updated: 3/4/2016*