



## 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 Austin ENT 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.

Austin Ear, Nose & Throat Associates  
3705 Medical Parkway, Suite 310  
Austin, TX 78705

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 Austin ENT Associates.

TX141

**Patient Information**

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

**Release Information To**

I hereby authorize Austin ENT Associates 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 re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state Austin ENT 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 Austin ENT Associates, except to the extent that Austin ENT Associates 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"**

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 11/9/2016