



Patient Instructions to Obtain Copies of Medical Records

Thank you for allowing QueensCare Health Centers the opportunity to be your health care provider. Please review the following guidelines and instructions to expedite receipt of your medical records.

California law (AB610) allows the health care 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. QueensCare Health Centers' turn-around time is about 15 business days depending on the location of your medical records (off-site storage, health center locations, etc).

The growing number of Federal and State statutes regarding privacy and security of your personal health records has necessitated that QueensCare Health Centers 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 QueensCare Health Centers charge a nominal fee to offset some of these increased operating costs.

We have employed BACTES Imaging Solutions to be the service provider for fulfilling your medical record requests. We have provided you a Medical Record Request Packet (attached) with instructions to request and pay for copies of your medical records. In order to process your request, please complete and submit the following two documents—together—to our **Release of Information** personnel.

- Authorization for Use or Disclosure of Health Information form
- Medical Record Request Payment form with \$15.00 pre-payment

Please note the following:

- We **do not** accept authorizations or payment forms by fax.
- We **do not** accept cash. Only check, money order or credit card is acceptable payment.
- Incomplete or missing information from your Authorization may impact and delay the turn-around time of your request. A patient service center representative will follow up with you if your request is not complete; **incomplete requests will be voided after 30 days.**

You may mail or drop off your packet in person to the QueensCare Health Centers Release of Information Department at the address noted below or complete the packet and leave it at one of our convenient **QueensCare Health Centers locations**. The health center will forward your request to our **Release of Information Department below**:

QueensCare Health Centers
Attn: **Call Center**
950 S. Grand Ave., 2nd Floor South
Los Angeles, CA 90015

Our personnel stand ready to assist you in completing the attached forms and answering any questions that you may have about the required information. After submitting the attached information, if you have questions about the status of your records, please call our patient service center for assistance at 800.560.3800. Please allow three business days before calling.

Thank you for allowing us to serve you,
QueensCare Health Centers



What to Expect When Requesting Medical Records

U.S. and California legislation has been enacted to protect you, the consumer, against those who would fraudulently use your personal information including personal health information contained in your medical records.

Every medical provider has unique processes and procedures in handling the release of information. At QueensCare Health Centers, we provide a standard set of records and medical information when responding to requests for information which adhere to the strict guidelines mandated by your Federal and State government.

The medical information provided to you documents the care given to you during your treatment at QueensCare Health Centers. What follows is a summary of the information categories with a brief explanation of what QueensCare Health Centers provides when fulfilling medical record requests.

☛ **IMPORTANT NOTE:**

Please be aware QueensCare Health Centers, by law, must provide the *minimum required* information and can only release information you have *specifically* requested and authorized in the QueensCare Health Centers authorization form, nothing more. If no specific direction is given, QueensCare Health Centers will provide one (1) year of pertinent information as defined below.

WHAT IS PROVIDED

- **Health center Notes:** A method of documentation employed by health care providers to write out notes in a patient's chart.
- **History & Physical (H&P):** A report which documents relevant information regarding the patient's current health condition. Information includes responses to personal and family medical histories and organ system examinations in sufficient detail to manage the patient's present condition.
- **Consultation:** A report documenting the diagnosis, prognosis and treatment of the patient's case.
- **Lab:** The most recent laboratory reports performed for the patient.
- **Radiology:** All radiology reports (CT Scans, MRIs, Ultrasounds, X-rays, and Nuclear Medicine Studies).
- **Diagnostic Studies:** Most recent EKG's, Echocardiograms & reports dealing with the heart.
- **Surgery / Pathology:** Operative reports which document all aspects of surgery and the findings of any specimens removed and sent for diagnosis.

WHAT IS NOT PROVIDED

Billing, Films, Pathology Slides or Outside Records.

The above information may be obtained by contacting these departments directly.



QueensCare
HEALTH CENTERS



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Last Name: _____	First Name: _____	Middle Name: _____	Date of Birth: _____
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Use and Disclosure of Health Information

I hereby authorize the use or disclosure of my health information as described below:

Person/organization authorized to provide the information	Person/organization authorized to receive the information
Name: _____	Name: _____
Agency/organization: _____	Agency/organization: _____
Address: _____	Address: _____
City/State/ZIP: _____	City/State/ZIP: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

This authorization applies to the following information:

- a. All general information (from _____ to _____) pertaining to my medical history, mental or physical condition and treatment received
- Information regarding specific injury or treatment (from _____ to _____): _____
- X-Rays (from _____ to _____): Reports Films
- Laboratory results (from _____ to _____)
- Confidential adolescent (12-17 years old) visit information (requires add'l. signature on pg. 2)
- Employee medical records (including pre-employment and annual physical documentation)
- Other: _____

b. I specifically authorize release of the following information (check as appropriate)

- Mental health treatment information¹ HIV test results Alcohol/drug treatment info.

Note: A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose of the Use or Disclosure

- Patient request (option **not** valid if healthcare provider/health plan is requesting the authorization)
- Other (please describe): _____

Expiration

This authorization expires (please check one):

- in 90 days or when the authorized information has been released, whichever comes first
- at the end of the research study (only if authorization is to use/disclose info. for research)

Answer next question only if a healthcare provider/health plan is requesting authorization.

Will the provider or plan receive compensation for use or disclosure of the requested information?

- Yes No

¹ If requesting that mental health information covered by the Lanterman-Petris-Short Act be released to a third party, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented.

My Rights

- I understand that this authorization applies only to treatment or services received on or before the date below and not to any subsequent treatment or services.
- I may refuse to sign this authorization. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization (except in the case of research-related treatment, pre-enrollment underwriting or risk determinations or provision of healthcare solely for the purpose of creating health information for disclosure to a third party). Under no circumstances may I be required to authorize the disclosure of psychotherapy notes.
- I may revoke this authorization at any time, but I must do so in writing, signed by me and delivered to QueensCare Health Centers, 950 S. Grand Ave., 2nd Floor South, Los Angeles, CA 90015. My revocation will be effective upon receipt, but it will not apply to information that already had been released in response to this authorization.
- I have a right to receive a copy of this authorization. If a health plan or healthcare provider has requested the authorization, I must be provided with a copy of this form after I sign it.
- I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal privacy law (HIPAA). However, California law prohibits the recipient of my health information from making further disclosure of it unless I provide another authorization for such disclosure or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the information described on this form.

Signature

Signature of patient/legal representative

Date

Printed name of patient/legal representative

If legal representative, relationship to patient

Adolescent Approval (required for release of adolescent-sensitive services information)

Signature of Minor (12-17 years old)

Date

Medical Provider Approval/Comments (required for release of Mental Health treatment info.)

Request approved by: _____

Date: _____

If denied, state reason why: _____

Comments: _____

Delivery method: CD Mail Pick-up at Processing Center Pick-up at _____
Name of health center

Encrypted email (covered entity to covered entity **ONLY**) to: _____
Recipient's Email address

Authorization received by: _____ on: _____



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: _____ Patient 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:** _____

Amount to be charged: _____

Name on Credit Card: _____

Signature of credit card holder: _____

Patient Billing Address: _____

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)

60+ pages = \$0.25 per page

Please be advised, you will be receiving a separate invoice from Bactes for additional shipping and handling fees.

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: _____