

Disclosure Process and Fee Explanation Letter

Thank you for allowing 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 or Radiology requests.

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 Facey Medical Group. California law allows a medical group 15 business days to produce copies of your medical records from the date your authorization is received ([CA H&S Code 123110\(b\)](#)).

Under federal and state law, Facey Medical Group or its medical records Release of Information provider, Sharecare Health Data Services, LLC (Formerly BACTES), 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 only the labor, materials and postage as allowed by HIPAA and highlighted by the Omnibus Final Rule. The requested output method will impact the cost to you. For all but very small records (10 pages), CD delivery will cost less than printed records so please indicate your preference. **As an example: on a 40 page record that includes, labor, materials and postage it would cost \$10.42 on CD and \$11.84 on paper.** Radiology request fees are different and will apply.

If records are needed for transfer of care purposes and are sent directly to a Physician or other Healthcare Facility, the last 12 months of records will be mailed or sent electronic format free of charge. Email must be provided on the release form.

Please fill out the attached authorization form completely and submit via fax, email, mail or drop off at your nearest Facey location.

Request by Fax: (818) 743-5343

Request by Email: roirequests@facey.com

Request by Mail: Facey Medical Group
Attn: Release of Information Department
11333 N Sepulveda Blvd
Missions Hills, CA 91345-1196

Once your request has been processed, you should receive an invoice within 5-7 business days. You may also check status of your request or pay the invoice online (Links provided below).

Check Status: <https://recordstatus.sharecare.com>

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

Pay Online: <https://payment.hds.sharecare.com>

Pay by Mail: Sharecare Health Data Services (HDS)
8344 Clairemont Mesa Blvd. Suite 201
San Diego, CA 92111

To Receive Records Electronically: <https://payment.hds.sharecare.com/Accounts/Verify>

Your request will be fulfilled upon payment. For questions, please contact Sharecare HDS at (800) 560-3800 #2 or Facey Medical Group Medical Records Department at (818) 837-5668.

**** DO NOT SCAN ****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Attention: Release of Information Department

Office (818) 837-5668 Fax (818) 743-5343 Email roirequests@facey.com

Address: 11333 N. Sepulveda Blvd, Mission Hills, CA. 91345

Type of Records Requested: (If selecting more than one option, additional charges may apply)

- Paper copy of records | CD Copy of records | E-Mail records
- Inspection of records (by appointment only - allow 5 business days)
- Transfer Request to another Medical Care Provider *(The last 12 months of visits will be provided at no cost when sent directly to a Physician or other Medical facility)*

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

Patient Name: <i>(Please print clearly)</i>	AKA:	Date of Birth:
Address:	City State:	(____) _____
	Zip Code:	Contact Phone Number:

Please **SEND** medical information **TO:**
(Check if same as above)

Name of Person or Entity to Receive Information
Street Address
City, State and Zip Code
Telephone/Fax
Email

Please **REQUEST** medical information **FROM:**

Name of Medical Office/Provider
Street Address
City, State and Zip Code
Telephone/Fax
Email

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 upon request.

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.

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General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Records also may include Images, information and treatment of mental illness, the use of alcohol, drugs and tobacco, but excludes Behavioral Health notes.

Check the box and indicate which type of information is to be released

- Transfer of Care to another medical facility *(The last 12 months of visits will be provided at no cost when sent directly to a Physician or other Medical facility)*
- All General Medical Information
- General Medical Information *(date range)* from _____ to _____
- Information regarding specific injury or treatment *(specify)*:

- X-ray Ultrasound Mammogram | Reports or Radiology CD (\$6.50)
(If a box was checked above, please add date range) from _____ to _____
- Bone Density Test
- Laboratory results *(date range)* from _____ to _____
- Immunizations
- Behavioral Health **Only** *(date range)* from _____ to _____

Signature of Patient or Representative

***There is no option for pick-up of records.**

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)

OFFICE USE ONLY

Request processed by: _____ / _____ Date: _____
Approved by (Please print) (Signature)

Released by: _____ / _____ Date: _____
Approved by (Please print) (Signature)

If denied state reason why: _____ Date: _____
Denied by (Please print and sign)

Sharecare HDS Use Only (Sharecare HDS copied date stamp) →

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