Disclosure Process and Fee Explanation Letter

Thank you for allowing Providence Medical Institute (PMI) 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 Providence Medical Institute. California law allows a medical group 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, Providence Medical Institute 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 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 it via fax, email, mail or drop off at your nearest PMI location.

Request by Fax: **(310) 792-6390**
Request by Email: **capmirecords@providence.org**
Request by Mail: Providence Medical Institute
Attn: Release of Information Department
11333 N Sepulveda Blvd
Mission Hills, CA 91345-1196

Once your request has been processed, you should receive an invoice within 5-7 business days. You may also check the 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 Providence Medical Institute Medical Records Department at **(818) 847-6966.**

**** DO NOT SCAN ****

Providence

EMRN: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Attention: Release of Information Department
Office (818) 847-6966 **Fax** (310) 792-6390 **Email** capmirecords@providence.org
Address: 11333 N. Sepulveda Blvd, Mission Hills, CA. 91345

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

Copy of records ☐ Paper ☐ CD | ☐ Copy of Images on CD ($6.50)
☐ E-Mail records | ☐ E-Mail Images
☐ 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: ***(Please print clearly)***	AKA:	Date of Birth:
Address:	City State: Zip Code:	(_____) _____ Contact Phone Number:

Please **SEND** medical information **TO**: (*Check if same as above*☐)	Please **REQUEST** medical information **FROM:**
Name of Person or Entity to Receive Information	Name of Medical Office/Provider
Street Address	Street Address
City, State and Zip Code	City, State and Zip Code
Telephone/Fax E-mail	Telephone/Fax E-mail

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 Providence Medical Institute.

Right to Copy: I have a right to receive a copy of the Authorization upon request.

Re-Disclosure Statement: I understand that once Providence Medical Institute discloses my health information to the recipient, Providence Medical Institute 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.

Scan under Auth. and Consents – ROI/Legal

Providence

EMRN: _____

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 ☐ Images on 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

Sensitive Health Information (not released unless specified):

- ☐ Reproductive Health _____ ☐ Gender Affirming Care _____
  Initials ***Initials***
- ☐ 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 Providence Medical Institute 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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