Gracelight Community Health

sharecare | HEALTH DATA SERVICES

We treat *every* medical record as if it were our own.

Patient Instructions to Obtain Copies of Medical Records

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

Disclosure Process and Fee Explanation

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 Gracelight Community Health. 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, Gracelight Community Health or its medical records Release of Information provider, Sharecare Health Data Services, LLC (Formerly BACTES Imaging Solutions), 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. As an example, if a 40-page record costs you $ 11.84 on paper, a CD will cost you $10.42.

We have provided you a Medical Record Request Packet (attached) with instructions to request copies of your medical records. In order to process your request, please complete and submit the Authorization for Use or Disclosure of Health Information Form to our Release of Information personnel.

Please note the following:

- We **do not** accept authorizations by fax.
- Incomplete or missing information from your Authorization may impact and delay the turnaround 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 Gracelight Community Health Release of Information Department at the address noted below or complete the packet and leave it at one of our convenient **Gracelight Community Health locations.** The health center will forward your request to our **Release of Information Department below:**

Gracelight Community Health
Attn: **Medical Records Department**
4618 Fountain Ave
Los Angeles, CA 90029

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 once assisted, you may be transferred to the Medical Records Department for further assistance. Please allow 5 - 7 business days before calling.

Thank you for allowing us to serve you,
Gracelight Community Health

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 Gracelight Community Health, 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 Gracelight Community Health. What follows is a summary of the information categories with a brief explanation of what Gracelight Community Health provides when fulfilling medical record requests.

IMPORTANT NOTE:
Please be aware Gracelight Community Health, by law, must provide the minimum required information and can only release information you have specifically requested and authorized in the Gracelight Community Health authorization form, nothing more. If no specific direction is given, Gracelight Community Health 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.

Gracelight Community Health

Patient Record: _____

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:

Use and Disclosure of Health Information

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

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

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 information ☐ 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

The 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 healthcare provider/health plan is requesting authorization.
Will the provider or plan receive compensation for use or disclosure of the requested information?

☐ Yes ☐ No

Gracelight Community Health

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 Gracelight Community Health, Medical Records Department, 4618 Fountain Ave, Los Angeles, CA 90029. 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: _____

Gracelight Community Health

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 costs of producing the requested records.

*** Important ***

Please note payment will not be collected by Gracelight Community Health. Sharecare Health Data Services will provide an invoice and collect the payment.

Date:_____ Patient Record #: _____

Patient Name: _____ Daytime contact #: _____

Payment Method (To be completed by patient) NO CASH ACCEPTED

☐ Check (payable to: Bates) ☐ Money Order ☐ Credit Card (MC, Visa, AMEX)

Check/Money Order #: _____

Credit Card #: _____

Expiration Date: _____ 3 Digit Security Code:_____

Amount to be charged: _____

Name on Credit Card:_____

Signature of Credit Card holder: _____

Patient Billing Address: _____

_____

_____