FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

Authorization for Release of Medical Information

Patient Instructions to Obtain Copies of Medical Records

Thank you for allowing the 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.

California law (AB610) allows the healthcare 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.

Under federal and state law, Facey Medical Group or its medical records Release of Information provider, 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 labor and materials as defined by HIPAA and highlighted by the Omnibus Final Rule.

This fee is cost-based to include: labor, supplies, and postage (if applicable). How the record is stored (Record Source) and delivered (e.g. Paper, CD, eDelivery) are variable factors affecting the fee.

We have provided you with a Medical Record Request Packet (attached) and instructions to request copies of your medical records. In order to process your request, please complete and submit the following material to our **Release of Information** personnel.

You may mail (see address below) e-mail (roirequests@facey.com) or drop off your packet in person to the Facey Medical Record Release of Information Department at the address noted below or complete the packet and leave it at one of our convenient **Facey clinic locations**. We will forward your request to our **Release of Information Department.**

Drop Off or Mail Only
Facey Medical Group
Attn. **Release of Information Department**
11333 N. Sepulveda Blvd
Mission Hills, CA 91345-1196

An invoice will be sent within 5-7 days of receipt to the address on your request. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by Check or Credit Card.

Pay by Phone: (800) 560-3800 Press #2 for Customer Service – Leave message for call back if no live contact

Pay by Mail: BACTES Imaging Solutions
8344 Clairemont Mesa Blvd. Suite 201
San Diego, CA 92111

Pay Online http://www.bactes.com/
Click on Pay Online - Top left selection - https://payment.bactes.com/Payments/
Enter your email address for Receipt – Invoice # - Amount of Invoice

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

Should you have any questions about the status of your records after submitting the attached information, please call Release of Information Department at 818-837-5668.

Thank you for allowing us to serve you Facey Medical Group

DO NOT SCAN

FACEY MEDICAL GROUP
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EMRN: *Site:*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Attention: Release of Information Department
Office (818) 837-5668 **Fax** (818) 743-5343 **Email** roirequests@facey.com
Drop Off Only 11333 N. Sepulveda Blvd
Mission Hills, CA. 91345

Type of access requested: (If selecting more than one (1) option, additional charges may apply)

☐ Paper copy of records ☐ CD Copy ☐ Inspection of records (by appointment only *- allow 5 business days*)
☐ Radiology CD ☐ Transfer Request *(12 months of visits will only be provided)*

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

________________________________ __________________ ______________________
Name of Patient (***Please print clearly***) AKA Date of Birth

____ (_____) _____________
Address City State Zip Code Contact 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

Please **REQUEST** medical information **FROM:**
(To be used when requesting outside records to come to Facey)

____
Name of Medical Office/Provider

____
Street Address

____
City, State and Zip Code

____
Telephone Fax Number

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 after I sign it.

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.

Rev. 09/21/16

SEND TO: Scan under ROI/Legal*
REQUEST FROM: Scan under Outside Records*

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EMRN:

SPECIFY RECORDS TO BE RELEASED

(Check the box and initial which type of information is to be released)

- ☐ All General Medical Information (from _______to _______). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may included information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.
- ☐ Information regarding specific injury or treatment (from_________ to _________)
- ☐ Radiology (*check what is needed*): (from_____ to _____)☐Reports ☐CD ($18.) *(CD Format requires 72 hours processing time)*☐Ultrasound *(Excludes Mammography Images-Use Mammography Image form)*
- ☐ Bone Density Test
- ☐ Laboratory results (from_____ to _____)
- ☐ Mental health Only (from_____ to _____) ***(Psychotherapy sessions)***

____
Signature of Patient or Patient's Representative

- ☐ Immunizations Only
- ☐ Other (Specify): ____
- ☐ Transfer of Care (Last 12 months)

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)

Your medical record request will be mailed to the address provided.

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)

Bactes Use Only (Bactes copied date stamp) ⟶

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