WOMEN'S SPECIALISTS of New Mexico

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# Disclosure Process and Fee Explanation Letter Women's Specialists of New Mexico

Dear Patient:

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 Women's Specialists of New Mexico. To assure we are doing everything we can to comply with HIPAA rules and protect the privacy of our patients, we have partnered with Sharecare Health Data Services (HDS), a national Release of Information provider, to assist us with this process. Under federal and state law, Sharecare HDS 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, materials and postage as defined by HIPAA and highlighted by the Omnibus Final Rule. How the record is stored and delivered are variable factors affecting the fee.

To minimize this fee, we encourage you to limit your request to just the records that you truly need. *Note that on the attached authorization form, there is an option to select a 2-year abstract plus 5 years of labs, radiology, and diagnostics*. For many patients, this option is sufficient for their purposes and keeps their bill lower than it otherwise would be.

Please fill out the attached authorization form completely and submit via fax or mail to:

Women's Specialists of New Mexico
1001 Coal SE
Albuquerque, NM 87106

FAX: 505-247-9743

Please note that the Sharecare HDS quality control process does extend the turn-around-time for your request to be fulfilled. However, you can expect that an invoice will be mailed to the address on your request within 5-7 business days. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by Check or Credit Card.

**Check Status 5-7 business days after submitting request:** https://recordstatus.sharecare.com/

**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

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

Your request will be fulfilled upon payment. For questions, please contact Sharecare HDS at **(800) 560-3800** and press 2 for Sharecare HDS Customer Service.

Thank you again for your confidence in Women's Specialists of New Mexico.

WOMEN'S SPECIALISTS of New Mexico

# WOMEN'S SPECIALISTS OF NEW MEXICO, LTD.

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## AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth _____

Address _____ City_____State_____Zip_____

Phone Home # _____ Work # _____

**Request Records From:**

Name/ Facility: _____ Attention: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

**Release Records to:**

Name/ Facility: _____ Attention: _____

Address: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

Purpose: ☐ Personal ☐ Cont. of Care/ Referral ☐ Insurance ☐ Legal ☐ Transferring Care

**NOTICE**: I authorize the use or disclosure of the named individual's health information as described. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**Information to be released (choose one option):**

- ○ Provide a 2 year abstract (including 5 years of labs, radiology, and diagnostics)
- ○ Please provide ONLY the following records within the date range listed below:
  ___ Progress Note/ Consult ____ Labs ___ Radiology Reports ___Pathology ____ Other _____

  From _____To _____

Comments/ Authorization Specifications: _____

**NOTICE:** This authorization is valid for 6 months from the date signed. You may revoke this authorization at any time by providing a written statement to the Health Information Management Dept. at Women's Specialists of New Mexico, except to the extent that WSNM has already completed actions on it.

**Potential Fees**: See the "Fees and Process Explanation Letter" for more information regarding associated costs.

### Authorization to Release Protected Health Information

**REQUIRED**: Please complete the checked boxes below indicating how protected information should be handled, even if the categories do not necessarily apply to the patient's medical records.

I ☐ DO ☐ DO NOT want information about communicable or sexually transmitted diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), genetic testing, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

*Initial below to confirm your choice*

Initial _____

Sign Here

Date Here

_____ _____

Patient's Signature Date

_____

Parent/ Legally Recognized Representative Signature

_____

Description/ Proof of Authority to Act on Patient's Behalf

**Know Your Rights**
Refer to the HIPAA **"Notice of Privacy Practices"**

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