

NORTH ALABAMA
BONE & JOINT
CLINIC, P.C.

Dear Patient:

BACTES Imaging Solutions, a trusted Business Associate of North Alabama Bone & Joint Clinic, is happy to assist you with your request for a copy of your medical record.

Please fill out the attached form carefully, indicating where you would like the requested information delivered, in the “Release Information To” section.

Please note, in order to fulfill your request, BACTES will impose a reasonable, cost based fee for copying in accordance with Alabama Law (Section 12-21-6.1). You will be responsible for the charges incurred in the release of your protected health information.

The following fees may apply:

Search fee: \$5.00 per request

Copy Fee: \$1.00 per page for the first 25 pages

\$0.50 per page thereafter

Postage, if applicable

You will be contacted by a BACTES Representative after submitting your request to provide payment. Once payment is received, records will be mailed to you.

For Records being sent to Another Health Care Provider

Please provide as much contact information for your other Doctor in the “Release Information To” section and select the preferred delivery method (Faxed or Mailed).

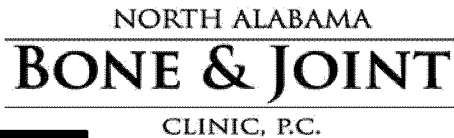
There is no charge for records delivered to another healthcare provider for ongoing treatment purposes.

You can contact our BACTES representatives at any time by calling 1-877-550-2083.

Thank you,

Medical Records Supervisor

Authorization to Disclose Protected Health Information



The undersigned authorizes
North Alabama Bone & Joint Clinic, PC
2129 Helton Drive • Florence, AL 35630
Ph. 256-246-3423 • Fx. 256-246-3297

to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names During Treatment? _____
Patient Address: _____ Date of Birth: _____
City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

Section must be filled out completely for request to be processed.

Name/Facility: _____ Attention: _____
Address: _____ Phone: _____
City: _____ State _____ Zip: _____ Fax: _____
Purpose of Request: Personal Treatment Legal Insurance Disability
 Transfer/Reason _____ Other _____
Please forward the Records by: Mail Fax
Will be mailed unless otherwise noted (For Doctor's Office Only!)

Information to be Released

- Please provide a **1 year** abstract of my records
(includes most recent notes, labs, diagnostic testing)
- Please provide a **2 year** abstract of my records
- Please provide my **entire** record
- Other** (please specify): _____

I understand I will be responsible for the charges incurred in the release of my protected health information. The following fees may apply: Search fee: \$5.00 per Request

Copy fee: \$1.00 per page for the first 25 pages
\$0.50 per page, thereafter.

(See AL Statute Section 12-21-6.1)

Records being sent to another healthcare provider will be provided at **no cost.**

Please provide an email address to have invoice sent. If you do not have an email, an invoice will be mailed to address provided above.

Authorization to Release Protected

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (initials of Patient or Legal Representative)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I can request a copy of this form after I sign and date it.

*Please confirm that you have initialed the protected information categories above, regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature _____ **Date:** _____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

***Verified identity by: (Please check the applicable box below or provide further explanation)**

Driver's License Military I.D. (Proof of Legal Guardian, Attorney of Record, Insurance) Other: _____