DSA DALLAS SARCOMA ASSOCIATES

sharecare

Disclosure Process and Fee Explanation Letter
Dallas Sarcoma Associates

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 Dallas Sarcoma Associates. 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:

Dallas Sarcoma Associates
12222 North Central Expressway #210
Dallas, TX 75243
FAX: 214-615-1949

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.sharecare.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 Dallas Sarcoma Associates.

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Authorization For Use or Disclosure of Medical Record Information Dallas Sarcoma Associates

sharecare

TX22025

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

Email Address: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize Dallas Sarcoma Associates to release my medical record information to:

☐ Mail Copies To: ☐ Discuss Medical Information With:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ◯Personal ◯Continuing Care ◯Insurance ◯Legal ◯Transfer (*Explain*) ◯Other (*Explain*)

Comments/ Authorization Specifications: _____

NOTICE: The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to federal and/or state privacy laws. Dallas Sarcoma Associates will not condition treatment on the signing of this Authorization or payment of associated fees.

Information to be Released

◯ Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

◯ Please provide my entire medical record for dates: From_____To_____

◯ Please provide my entire billing record for dates: From_____To_____

◯ Please provide *only* the following records within the date range listed below:

___ Progress Notes/Consults ___ Labs ___ Radiology Reports ___ Pathology ___ Billing ___ Other (*Explain Below*)

From _____ To _____

Comments/ Authorization Specifications: _____

NOTICE: This Authorization is valid for 365 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department at Dallas Sarcoma Associates, except to the extent that Dallas Sarcoma Associates has already completed action on it.

POTENTIAL FEES: See the "Fee and Process Explanation Letter" for more information regarding associated costs.

Authorization to Release Protected Information

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

Release Records? Check one — *Initial each line below to confirm your choices*

I ☐ DO ☐ **DO NOT** want ***Psychotherapy Notes** released _____

I ☐ DO ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ DO ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ DO ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

STOP AND REVIEW: Please confirm that you have put a checkmark and initialed **ALL** 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.

NOTICE TO RECIPIENT: Federal rules prohibit further disclosure, by the recipient, of any alcohol or substance abuse records released under this Authorization, unless the recipient has received written consent from the person to whom It pertains or as otherwi se permitted by 42 CFR Part 2.

Sign Here _____ Date Here _____

Patient's Signature **Date**

Parent/Legally Recognized Representative Signature **Date**

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

Know Your Privacy Rights
Refer to the HIPAA

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