Medical Records Processor
26081 Merit Circle, Suite #109 Laguna Hills, CA 92653
Phone (949) 582-7699 Fax (949) 582-7691(rev 05/12)

MEDICAL RECORDS FAQ'S:

- **How many days will it take to obtain my records?**

Please allow 5 to 15 working days for your request to be processed. If you have requested your records to be mailed, they will be promptly mailed first class via the U.S. Postal Service to the address you specify on the authorization form. Rush requests may be accommodated but not guaranteed. Records in storage may require longer periods.

- **Are records available directly from your office?**

Medical record processing and compliance with HIPAA are complex and therefore are outsourced. All records requests are processed through the Medical Records Department and Certified Processor. The Skin Center medical staff do not handle record requests. All medical providers are required under California's Confidentiality of Medical Information Act to obtain an original, complete and properly executed Authorization for Release of Medical Information form before we can provide copies of health records to patients or their representative. Return the completed form by mail to the medical records department where you received care.

- **Can I just call in/walk in for my records?**

A completed written and signed record request is required for all record releases. Walk-in or verbal requests are not valid forms of records authorization.

- **Am I entitled to free medical records?**

  Standard record fees are $50 processing/clerical fee plus 25 cents per page and are payable in advance. All patients **pay the fee required to obtain copies for personal use** If you have questions about your invoice, please contact our outside copy service.

- **Can I get a discounted price for my records**?

Yes. A discounted initial record request of $35 plus 25 cents per page may be extended to you as a one-time courtesy for a prepaid and properly filled out request. Requests that have to be sent back for completion or payment will not be eligible for the courtesy discount. Additional record requests will carry undiscounted fees.

- **Weren't records provided for free before HIPAA?**

Yes, however there has been an administrative charge for all records for more than 3 years.

- **Is charging for medical records standard policy?**

Yes. This policy is in accordance with California Health & Safety Code section 123110. Pre-payment is processed prior to release of records.

- **What if I am seeing another doctor?**

If you would like your medical records mailed to a physician or medical facility, you or your new physicians may pay the copying fees $0.25 per page in addition to processing & postage fees .You will need to fill out a completed TSC form.

- **Can I bill my insurance for my records?**

You can contact your insurance carrier about their coverage policies. Most insurances consider medical records a non-covered service.

- **Can I have my records faxed?** To ensure full privacy, records are mailed out by U.S. Mail.

THE SKIN CENTER:
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please read carefully and complete page 2 of this form. All sections of this authorization must be completely filled out before TSC is permitted to disclose your protected health information.

We keep records of the medical care we provide you and we may receive similar records from others. We use this information so that we, or other health care providers, can render quality medical care, obtain payment for services and enable us to meet our professional and legal responsibilities to operate our medical practice. We may store this information in a chart and in our computers. This information makes up your medical record. The medical record is our property; however this notice explains how we use information about you and when we are allowed to share that information with others.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. TSC cannot condition services on whether or not you sign this authorization except under limited circumstances such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as worker's compensation). In these circumstances, TSC may refuse services unless you provide an authorization for the disclosure of your information. **Please be aware that once your information leaves TSC, TSC will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION:
Federal and State laws require us to obtain specific authorization from patients to release sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results; Psychiatric, Alcohol or Drug Abuse Treatment. Be aware that **you are authorizing the release of all aspects of your medical records including this sensitive information.** We will not exclude these types of information unless you specifically identify them for non-release. If you know your record contains this type of information, you must identify the specific type of information. If you choose not to release this information, please notify us immediately in writing.

DURATION: I understand this authorization may be revoked in writing at any time, according to the instructions in TSC Notice of Privacy Practices, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for one year.
RESTRICTIONS: I understand that TSC may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by laws I hereby release TSC from any/all legal liability that may arise from the release of this information to the party named above.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION:Please read carefully and complete page 2 of this form. All sections of this authorization must be completely filled out before TSC is permitted to disclose your protected health information.

Please initial that you have read the above statements _____
Printed Name Initials_____

Medical Records Department

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MEDICAL RECORDS RELEASE & FEE AUTHORIZATION

Patient NAME _____ **My Phone #:** _____

Birth date: _____ **Last 4 digits Social Security #:XXX-XX- _ _ _ _**

Records to be mailed to my home address:

Address **City** **State** **Zip**

What records are requested? (Be sure to specify actual dates below)*FEE $50+ 25cents/page applies

☑ HIV (Human Immunodeficiency Virus) test results ☑Psychiatric records ☑Alcohol and/or drug abuse treatment and/or use of

☐ Most recent labs ☐Most recent pathology report ☐All pathology reports ☐ Dates_____

☐All Records ☐Other: _____

Reason For Records Request :

☐ Personal records ☐ 2nd opinion ☐ Plastic Surgery ☐ Other:_____

☐ Permanently transferring care? Please, note reason:_____

☐ Moving/moved out of the area; please provide your new address and phone number:

Address City State Zip PHONE

I understand that someone from the medical records department may be contacting me to by telephone, fax, or mail to verify the information that I provided above. I hereby affirm that I am the person listed on this request. To comply with federal laws and protect my medical privacy, my signature and identifying information will be verified.

I understand that the authorization for release of records as detailed above, unless specifically limited by me in writing will extend to all aspects of treatment provided at The Skin Center. These records may include testing for all sexual transmitted diseases, AIDS, and hepatitis, as well as drug, alcohol and/or psychiatric information.

I understand that records are processed within 15 days of the date of the received written request. Medical records are ***not*** available on a walk-in or same day basis. All requests must be in writing and are handled by standard ground mail. Records are not faxed (to non-verified numbers). It is policy that a clerical copying fee of $50.00 plus $0.25 for each page printed, for the printing of patient medical records through the medical records department. This is in accordance with Health & Safety Code section 123110. Pre-payment must be processed prior to mailed release of records. I can choose payment by credit card, money order, or cashier's check, Paypal (to Billpay@theskincenter.org), or online at www.aderm.us.

I AUTHORIZE **$**_____ PAYMENT TO BE CHARGED ON CREDIT CARD BELOW: ☐**VISA** ☐**MASTERCARD**
CARD # _____ **EXPIRATION DATE:** _____ BILLING **ZIP CODE**:_____

I hereby release The Skin Center from all legal responsibility of liability for the release of the above disclosure of my information. I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. I agree that it is my sole responsibility to contact The Skin Center if I have not received my records by 15 days. **I understand that incomplete forms and those received without proper payment will be considered invalid, thereby causing an automatic cancellation of my record request.**

Date:_____ **Signature**:_____

MEDICAL RECORDS PROCESSOR USE:

☐Fee Processed $_____ ☐Date Released_____