# COMPREHENSIVE ORTHOPAEDICS, S.C.

7401 104th Avenue Suite 110 Kenosha, WI 53142
Phone: 262-764-5595 Fax: 262-764-9314

**Authorization to use/or Disclose Personal Health Information**
**A copy of this authorization will have the same force and effect as the original**

Patients Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

## I AUTHORIZE:

Name & Address of Party you are **REQUESTING RECORDS FROM**: **Please see #5 below for charge information**.

Name: Comprehensive Orthopaedics, S.C.

Address: 7401 104th Avenue, Suite 110, Kenosha WI 53142

Name & Address of Party you want **RECORDS RELEASED TO**: mail, patient pick up, fax

Name: _____

Address: _____

***Record Request may take up to 7 – 10 business days to process***

## INFORMATION TO BE RELEASED

**Specify part of body:** _____

_____ Clinical Chart Notes _____ Lab/Pathology Reports _____ Hospitalizations _____Billing Records
____ Diagnostic Reports Only (X-ray, MRI, CT, EMG) _____ X-ray films _____ Other ____All records

For the following items to be included in the use or disclosure, in compliance with Wisconsin Statues, please release Records pertaining to:

_____ Mental Health _____ AIDS/HIV _____ Genetic testing
_____ Developmental Disabilities _____ Drug / Alcohol Abuse

## PURPOSE OF THIS DISCLOSURE:

_____ Physician / Second Opinion _____ Moving / Relocation
_____ Attorney / Litigation _____ Insurance Request _____ Other: _____

*(Office use Only)*
*Films to be released:* _____

_____ *# of films* _____ *Released By:* _____

1) I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by this regulation. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
2) I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.
3) I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.
4) I understand I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, enrollment in a health plan, or eligibility for benefits.
5) **There will be a charge for all records requested**, except for continuity of care when we refer you to another doctor and we send those records to that doctor's office, otherwise copies will be charged by our copy service Bactes. You will receive a pre-pay invoice directly from **BACTES** for this service. You may pay this invoice via phone, mail or web in order to have your complete records released.

_____
Signature of Patient / Legal Representative: Date

_____
Print Name: Relationship

Updated 09/06/17

BACTES™
a sharecare company

Comprehensive Orthopaedics, S.C.

**If you are in need of Medical Records:**

Please submit your request to your medical provider, Comprehensive Orthopaedics, S.C. and BACTES, its Business Associate, have partnered to provide your requested information in a compliant and timely manner. In accordance with the established process, Comprehensive Orthopaedics, S.C. will forward the request to BACTES for processing.

**If you are a Patient or Patient Representative:**

Your medical records are legal documents maintained by Comprehensive Orthopaedics, S.C.; you have a right to a copy of your medical information. Under federal and state law, we are allowed to recover certain costs related to making a copy of your medical records. If a fee applies to your request, you will receive an invoice after we determine the cost of processing your specific request. The fee we charge is cost-based and includes only the labor, materials and postage as allowed by HIPAA and highlighted by the Omnibus Final Rule.

The requested output method will impact the cost to you. For example, including labor, materials and postage, a 50 page record would cost approximately $12.50 if delivered via secure e-transmittal; $13.00 if printed on CD or paper and mailed using the postal service. The fee charged to patients will not exceed $25.00, plus delivery cost.

**After Your Request is Processed and Invoice is Received:**

| | |
|---|---|
| To pay online: | https://payment.bactes.com/Payments/ |
| To pay via mail: | BACTES Imaging Solutions<br>8344 Clairemont Mesa Blvd, Ste 201<br>San Diego, CA 92111-1327 |
| To pay via phone: | 800-560-3800, Option 2 |
| To sign up for e-Delivery: | https://payment.bactes.com/Accounts/Verify |
| To check the status of you request: | https://recordstatus.sharecare.com/ |
| If you need personal assistance: | 800-560-3800, Option 2 |

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