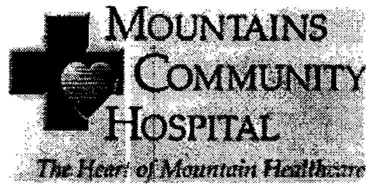

Instructions for Requesting Copies of Your Medical Record

California law (AB610) allows a 15-day turnaround time to process a patient's request for copies of their medical records. Our turn around time is about 5-7 days depending on the location of your medical records (storage, out patient department, etc). In order to provide you with quality service we have hired an outside service, Bactes Imaging Solutions (BACTES), to fulfill your request.

Due to HIPAA and State regulations we must follow strict guidelines when releasing copies of your medical records. We have provided you with a Packet and instructions to request copies of your medical records. In order to process your request please complete and submit all of the following in this Packet:

- ❑ Consent To Release Medical Information form
- ❑ Patient Pay Program form
- ❑ $15.00 Prepayment

You may mail or drop off your packet in person to:

Mountains Community Hospital
Attn. Medical Records
29101 Hospital Road
PO BOX 70
Lake Arrowhead, CA 92352

* Please note that we do not accept Packets by fax.

For questions regarding the Consent form please call: (909) 336-3651
For questions about the Patient Pay form please call: (909) 336-3651

Thank you for following these instructions and for your understanding,

Correspondence Desk
Mountains Community Hospital
"A Local California Healthcare District."

Mountains Community Hospital
The Heart of Mountain Healthcare

PATIENT PAY PROGRAM

Effective June 23, 2008

CA CIVIL CODE 123110: California Patient Access to Health Records. Inspection and copying; Paragraph (b) "Additionally any patient or patient's representative shall be entitled to copies of all or any portion of the patients records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed ($.25) per page or ($.50) cents per page for records copied from microfilm and any additional reasonable clerical costs at a rate of ($24.00) per hour".

Date: ________________ Medical Record #: ________________________

Patient Name: ___________________________ Daytime contact #: __________________

Payment Method (To Be Completed by Patient)

☐ Check (payable to: Bactes) ☐ Money Order ☐ Credit Card (MC, Visa, AMEX)

Check / Money Order #: ______________________________

Credit Card Number: ______________________________

Expiration Date: ____________ 3 Digit Security Code ______________

Name on Credit Card: ____

Signature of credit card holder: ____

Billing Address: ____

City State ZipCode

Charges for the cost of reproduction of medical records for <u>STANDARD</u> (5-7 days) processing:

1-50 Pages= $15.00 (payable at time of request) Check or Credit Card

51 Pages and over = $0.25 per page (Based on 1 inch = 110 pages) (payable at time of request)

Charges for the cost of reproduction of medical records for <u>RUSH</u> (*1-2 Hours*) processing:

Rush Fee= $30.00

1-50 Pages = Included (payable at time of request)

51 Pages+ pages = $0.25 per page (Per page will be based on 1 inch = 110 pages)

For Office Use Only

# of Inches _________ X 110 pages = _____________ pages <u>minus</u> 50 prepaid pages

= __________ pages @ $0.25 per page = **Total amount due:$**__________

Date patient notified of charges: ______________ Actual pages copied: ___________

P.O. Box 70, Lake Arrowhead CA 92352
Phone (909) 435-3061 – Fax (909) 336-9302

Revised 10/24/2008

Authorization To Release Medical Information

Explanation: This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 1980, Section 56, et. seq., of the California Civil Code.

I, the undersigned, hereby authorize Mountains Community Hospital and Rural Health Clinic to release such information as specified below, this will NOT include, information regarding HIV, AIDS, alcohol, and/or drug abuse, and/or psychiatric information, etc.

By signing below I authorize information regarding sensitive records such as: HIV, AIDS, alcohol and/or drug abuse, and/or mental health information to be released.

_______________________________ ______________

Patient Signature Date

Patient Identifying Information (Please Print):

_______________________________ ______________

Name of Patient Daytime Phone Number

Date of Birth: ______________ Date(s) of Treatment: ______________

Where Treated: ❐ In Patient ❐ Emergency Room ❐ Out Patient

Method of Release:

❐ Mail ❐ Pick-up ❐ Fax (Doctor Only)

Physician Name: ______________________

Phone #: ______________ Fax #: ______________

P.O. Box 70, Lake Arrowhead CA 92352
Phone (909) 435-3061 – Fax (909) 336-9302

Revised 10/24/2008

Where Medical Records Will be Mailed:

Name ______________________ Daytime Phone Number ______________________

Mailing Address of Requesting Party ______ City ______ State ______ Zip Code ______

Reason information is being requested: ______________________

Please check Package A or Package B
*** If only requesting a specific report and/or test please check the appropriate box(s)**

☐ Pertinent Records - Package A

☐ Discharge Summary	☐ Laboratory Tests	☐ Pathology Reports
☐ History and Physical	☐ Radiology Reports	☐ ER Report
☐ Consultation Reports	☐ Cardiology Reports	☐ Operation Reports
☐ Face Sheet		

☐ All Records -Package A and Package B

☐ Progress Notes summary	☐ Special test/therapy	☐ Labor/Delivery
☐ Physician Orders	☐ Nurses Notes	☐ Graphics
☐ Medications	☐ Rhythm Strips	

Note: It is understood that release or transfer of the above-specified information to any person/agency not named herein is prohibited. An additional written consent must be obtained for new use of the information or its transfer to another person/agency. It is also understood that the undersigned may revoke this authorization as it applied to drug and/or alcohol abuse information at any time, except to the extent that action has been taken of information was released prior to revocation. Otherwise this authorization shall be valid for **NO LONGER THAN 90 DAYS**.

I further understand that I have a right to receive a copy of this authorization upon my request. ______________________ or ______________________

Patient's Signature Personal Representative

______________________ Date signed: ______________

Relationship to Patient

P.O. Box 70, Lake Arrowhead CA 92352
Phone (909) 435-3061 – Fax (909) 336-9302