PHOTO-STAT, LP
P.O. Box 154385
Irving, TX 75015

Telephone: 972-399-0914 ext 204 Facsimile: 972-399-0960

Dear Patient:

Photo-Stat, LP is a regional medical record copying service which has been processing requests for medical records for over 18 years. Our service has been enlisted by Pure Health, Dr. Jayshri Chasmawala to handle the release of all medical records.

A fee of $33.80 is being assessed by Photo-Stat, LP for copying and transferring each set of medical records requested by the patient regardless of the recipient. Make checks/money orders payable to Photo-Stat, LP or complete the attached credit card form and remit to the above address. Once payment is received, please allow 7-15 business days for the recipient to receive a copy of your records. Original charts and Electronic medical records will always remain with custodian of records. Any corrections would need to be made on the enclosed authorization and mailed back with your payment. **Please note that we do not copy or send medical records until invoice is satisfied.**

If you have any questions or need further assistance please do not hesitate to contact Photo-Stat at 972-399-0914 extension 203 or by email: stephanie@photostat.org.

All medical records will be provided on a CD.

Thank You,

Photo-Stat Staff

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____ (Facility Name)

_____ (Facility Address)

_____ (Facility City/State/Zip)

To Release To: _____(Recipient Name)

_____(Street Address)

_____(City, State, Zip)

Telephone Number_____ Fax No._____

Email Address_____

The following information from the medical record of:

Patient Name: _____(first, last) Date of Birth:_____(mm/dd/yyyy)

Social Security No: _____-_____-_____ Date(s) of Treatment: _____ Telephone _____

Patient Address: _____ Email Address: _____

Information to be released:

□ Discharge Summary	□ History & Physical	□ Operative Record	□ Pathology Report
□ Laboratory Reports	□ Consultation Reports	□ EKG/ECHO	□ Blood Type
□ ER Records	□ Progress Notes	□ Radiology reports	□ Radiology films/CD
□ Complete Chart	□ Abstract/Basics	□ Face Sheet	□ Itemized Bill

□ Other (specify):_____

The information specified above is to be released for the following purpose:

□ Treatment/Consultation □ Patient Request □ Billing or Claims □ Attorney □ Social Security

□ Other (specify) _____

Substance Use/Abuse Treatment, Psychiatric, Genetic Testing, and/or HIV/AIDS Records Release

Federal and State law requires specific authorization from patients to release sensitive information. I understand that if my medical or billing record contains information in reference to drug, tobacco and/or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking Yes or No in the appropriate box. (TX HB 300)

Substance use or abuse treatment…	□ YES-Disclose	□ NO-Do not Disclose.
Psychiatric Care and/or mental health records…	□ YES-Disclose	□ NO-Do not Disclose.
Genetic Testing…	□ YES-Disclose	□ NO-Do not Disclose.
HIV/AIDS testing and/or treatment…	□ YES-Disclose	□ NO-Do not Disclose.

Time Limit and Right to Revoke

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new authorization. I desire this authorization to be in effect until _____ (expiration date/event). Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

Authorization and Re-disclosure

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

Preferred method of Reproduction: □ CD □ Email □ Paper - We will try to accommodate preference where practicable.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Authority to sign if not Patient (Documentation may be required)

Medical Records Service

Credit Card Payment Form

THIS SECTION TO BE COMPLETED BY CARDHOLDER

Patient Name: _____

Quote #: _____ Amount on invoice: $ _____
(**Please note that an additional 4% convenience fee will be charged when using this method of payment**)

PLEASE PRINT

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Card Number: _____ Expiration Date: _____

Security Code: _____

Type of Card: ( ) VISA ( ) Master Card

Signature: _____ Date: _____

Fax form AND copy of request to: Photo-Stat, LP at 972-399-0960
or mail to: Photo-Stat, LP, 120 S. Briery St., Irving, TX 75060