EHealth Management
Medical Records Fees Policy

To Whom It May Concern:

This is to inform regarding all medical records request will be under the following fee guidelines. Invoice will be issued once Medical Records Consent/Request is received. We will send the requested medical records within 10 calendar days after the payment is made. Additionally, separate fees will be charged for billing records: following same fee guideline as indicated below. Please write the check to **eHealth Management** or by credit card.

(Ref. Tex. Admin. Code #165.2)

$25	First 1-20 pages
$0.50	Per page after 20
$5.00	Postage fee except for overnight or expedite extra fees
$0.05	Supplies fee (per page after 20 pages)
$15/hour	Labor expense per hour

I have understood and agreed the abovementioned eHealth Management Medical Records release policy:

Patient Signature and date

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of

Patient name: _____ Date of Birth:_____

Social Security#: _____ Daytime Phone:_____

Medical Information Released

To:

Name: _____

Address: _____

_____

From:

eHealth Management

17200 State Hwy 249, Suite 100

Houston, Texas 77064

Please release the following:

___Problem List ___ Immunizations ___X-ray reports

___Progress Notes ___Lab reports ___X-ray films

___History/Physical Exam ___EKG reports ___ANY AND ALL RECORDS RELATING TO MY CARE

Including Information (If applicable) pertaining to:

___Mental Health ___Drug/Alcohol ___HIV/AIDS ___Communicable Treatment

Purpose or need for disclosure:

___Continued patient care ___Personal Use ___Disability Determination

___Attorney/Legal ___Insurance Clain/Application ___Other (specify)

I understand that the Information released is for the specific purpose stated above, Any other use of this Information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (In writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____

Signature of Patient or Legal Representation Date

_____ _____

Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT:

I understand that my medical record may contain reports, test results, and notes that *only a physician can interpret.* I understand and have been advised that I should contact my physician regarding the entries made in my medical record, my misunderstanding of the information contained in theses entries. I will not hold the practice liable for any misinterpretation in medical record as a result of not consulting my physician for the correct Interpretation.

_____ _____

Signature of Patient or Legal Representation Date

_____ _____

Relationship to Patient Witness

Date requested completed_____ # of pages_____Reviewed only

Charges $_____ Cash_____ Check_____ Initials_____