

If you are a Patient or Patient Representative:

Your medical records are legal documents maintained by Mountain View Medical Group; you have a right to a copy of your medical information. Mountain View Medical Group and BACTES have partnered to provide your requested information in a compliant and timely manner. Please submit your request to Mountain View Medical Group. In accordance with the established process, Mountain View Medical Group will forward the request to BACTES for processing.

Under federal and state law, we are allowed to recover certain costs related to making a copy of your medical records. 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. Medical record copies can be delivered on paper or on CD. In nearly all cases, the overall cost to you will be less when you choose CD as material and postage costs are minimized when compared to printed copies.

If a fee applies to your request, you will receive an invoice after we determine the cost of processing your specific request. Your records will be released in the format you requested within 48 hours after BACTES receives your payment. Payment can be remitted to BACTES by check, money order, or credit card. Please note that we cannot accept Flexible Spending Cards for payment.

Payment Options:

To make payment by phone:

1-800-560-3800

To make payment via mail:

BACTES Imaging Solutions
8344 Clairemont Mesa Blvd, Suite 201
San Diego, CA 92111

If you are a Third Party requesting patient records in accordance with HIPAA:

Mountain View Medical Group and BACTES, its business associate, have partnered to provide your requested information in a compliant and timely manner. Please submit your request, and the accompanying patient authorization, to Mountain View Medical Group. In accordance with the established process, Mountain View Medical Group will forward the request to BACTES for processing. If a fee applies to your request, you will receive an invoice after we determine the cost of processing your request. Records will be released in the format you requested within 72 hours after BACTES receives your payment. The invoice you receive can be paid, and the records you require can be accessed through our secure website.

Third Party Requestors:

To check the status of your request: <https://recordstatus.sharecare.com/>

To pay online: <https://payment.bactes.com/Payments/>

To sign up for e-Delivery: <https://payment.bactes.com/Accounts/Verify>

If you need personal assistance: 800-560-3800, Option 2

Patient Information:	Name: _____ Maiden Name/Alias: _____ Date of Birth: _____ SSN# _____ Phone: _____ Medical Record# _____	
Health Information Released FROM: <input type="checkbox"/> Mountain View Medical Group <input type="checkbox"/> Other: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____		Health Information Released TO: Person/Organization: _____ Street Address: _____ City/State/Zip Code: _____ FAX: _____ Phone: _____
Health Information to be RELEASED:	Date(s) of Treatment Received: _____ (If dates not specified, only the most recent year will be released) <input type="checkbox"/> Clinic Visits <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Labs <input type="checkbox"/> Radiology Images <input type="checkbox"/> Immunization <input type="checkbox"/> Other: _____ <p>All information regarding chemical dependency treatment, mental health and/or HIV or AIDS WILL BE RELEASED unless you tell us not to by initialing below:</p> ___ Do Not Release Chemical Dependency Treatment records ___ Do Not Release Mental Health records ___ Do Not Release HIV/AIDS records ___ By initialing here I give consent for Mountain View Medical Group to verbally communicate with the listed authorized recipient.	
Purpose of Release:	<input type="checkbox"/> Personal <input type="checkbox"/> Attorney <input type="checkbox"/> Continued Care - Appt Date: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Disability/ Social Security <input type="checkbox"/> Other: _____ <input type="checkbox"/> Transfer from Practice/Reason? _____ <p style="text-align: center;">There may be a charge/fee for copies of records</p>	
Delivery Method:	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick up by patient/authorized designee (requires valid photo ID)	
Authorization/Revocation:	This authorization will terminate in one year unless otherwise specified: _____. I understand that I may stop this release at any time by writing to the Mountain View Medical Group's Health Information Management department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Mountain View Medical Group will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. X _____ X _____ Signature (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.) Date _____ Relationship to patient (if not patient) <p>NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.</p> <p style="text-align: center;"><i>A photocopy of this authorization is as valid as the original.</i></p>	
Staff Use Only:	Info Released By: _____ Date: _____ Form of ID: DL State ID Passport Other: _____	