PHOTO-STAT, LP
120 S Briery Rd
Irving TX 75060

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

Dear Patient/Patient Guardian:

Photo-Stat, LP is a regional health information processing service which has been processing health information requests for over 20 years. We have worked in partnership with Baylor Garland over the last ten years to provide copies of medical records to their patients. As is our usual practice, you may obtain an abstract of your records without charge. An abstract consists of the primary parts of your medical record: Discharge Summary, Emergency Physician document, History & Physical, Procedure Reports, Consultations, and Test Results. If you desire a copy that includes every page of your medical record, a small fee of $25 is assessed.

Please complete all areas on the attached authorization and indicate if you desire an abstract or a complete record and return with a copy of your photo identification (driver's license, ID card, or passport). If the complete record is requested, send in with payment. You may remit this back via:

1. Mail: Photo-Stat, LP | 120 South Briery | Irving, TX 75060
2. Fax: 972-399-0960
3. E-mail: request@photostat.org

Please make checks/money orders payable to Photo-Stat, LP, or complete the attached credit card form. Once payment is received, please allow 7-15 business days for the recipient to receive a copy of your records. If you have any questions or need further assistance please do not hesitate to contact 972-399-0914, any customer service representative can assist you.

Thank You,

Photo-Stat

Credit Card Authorization Form

Patient Name: ____

Fee amount: $25.00

PLEASE PRINT

CARDHOLDER INFORMATION

Name:____

Billing Street Address:____

Street Address (cont.):____

City:_________________________ State:____________ Postal Code:_____________________

Country:________________________________ Email ________________________________

Address:____

Direct Telephone: (______)_______-____________

CREDIT CARD INFORMATION

Credit Card Type: ◻ MasterCard ◻ Visa ◻ American Express ◻ Discover Card

Number:____

Expiration Month:_______ Expiration Year:_______

Cardholder Signature X__________________________________ Date_____/_____/__________

Security Code:_________________

Please allow 7-15 business days to receive medical records

You may email this credit card form AND copy of authorization letter w/ID to:
request@photostat.org **or via fax to: (972) 399-0960, or**
mail to: Photo-Stat | 120 South Briery | Irving, TX 75060

We also accept checks and money orders

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Baylor Scott & White Health to disclose my individually identifiable health information as described below. 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 health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here ______________________________ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the Baylor Scott & White Health facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider. ☐ I would like to review my record

Patient Name	Last 4 of Social Security Number	Date of Birth / / (MM DD YYYY)	Acct #	MRN
Street Address	City, State,	Zip	Telephone Number	

Please release information from these BSWH facilities: BAYLOR SCOTT & WHITE MEDICAL CENTER - GARLAND

Please release the following information for these treatment dates: ______________________________

The information will be released to: ☐ Patient/Designee ☐ Health Care Entity ☐ Insurance Company ☐ Attorney ☐ Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other ____________

Record copy format: ☐ Paper ☐ CD ☐ __________ **Record copy delivery:** ☐ Pick-up ☐ Mail ☐ Fax to healthcare office

Information to be released:

Include this information if applicable: _______ Alcohol/Drug _______ Genetics _______ HIV/AIDS _______ Mental Health
(PT INITIALS under each)

☐ Summary Abstract only (clinic notes, history/physical, procedure reports, pathology, consultations, test results, discharge summary)

☐ Emergency Department ☐ Discharge Summary ☐ Medication ☐ Provider Orders
☐ Billing Record ☐ History/Physical ☐ Nurses' Notes ☐ Radiology Film
☐ Complete Chart ☐ Immunization ☐ Operative Reports ☐ Radiology Reports
☐ Consultations ☐ Laboratory ☐ Progress Notes
☐ Other: ______________________________

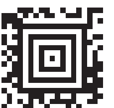
I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

______________________________ ______________
Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

______________________________ ______________
Printed Name of Patient or Legal Representative Relationship to Patient

____
Representative's Authority to Act for Patient
(attach supporting documentation)

** REMIT BACK WITH A COPY OF YOUR ID **



BSWH-49262 (09/15)