DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Roberts/FOIA	7-11-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000011	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Cox Cleared 7/16/13, letter attached	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 7-25-13 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Stratos Legal Records, LLC

4299 San Felipe, Ste. 350
Houston, TX 77027
713-375-0121 FAX: 281-200-0830

VIA: [ ] MAIL [ ] FAX: COVER AND ____ PAGES

CUSTODIAN OF RECORDS
South Carolina Medicaid
1801 Main Street
P.O. Box 8206
Columbia, SC 29202
Main: 803-898-2795 **Fax: 803-255-8338**

Please find enclosed a request for records of:

Cain Seagraves
DOB: 07/18/2003 SSN: 683-03-2545

We are requesting:

ANY AND ALL MEDICAID RECORDS, pertaining to Cain Seagraves, DOB: 07/18/2003, SSN: 683-03-2545, including but not limited to medical records, disability records, any records reflecting benefits applied for and received, any records reflecting benefits applied for and denied, claims history records, office notes, any type of report, any type of correspondence, and anything else reduced to writing in the possession, custody or control of the said witness, and every such record to which the witness may have access

IF RECORDS ARE STORED ELECTRONICALLY, PLEASE FORWARD ON CD. (Per the HITECH ACT)

Please call to confirm you have received our request. We will call you within 3-5 days for a page count and fee approval. IF YOUR FEES EXCEED $100.00, please call for approval before sending records. **Please have records sent by fax to (281)200-0830 or mailed to the address above.** If approval is not given or if an invoice is not sent with the records, we **WILL NOT** be responsible for charges. Thank you for your cooperation.

We need these records and legal documents returned **BEFORE:** _____.

Contact: Harmony Trevino

Order No. 57058.002

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: South Carolina Medicaid

RE: NAME: Cain Seagraves

ADDRESS:

CITY, STATE, ZIP CODE:

DOB: 9.18.2003 DOD: SS#: 683-03-2545

I authorize the individual or organization listed below, to disclose the above-named patient's health information, as listed to the following recipients: Stratos Legal Services, for the purpose of the above-named individual's personal injury claim.

The information to be used or disclosed is as follows:

1. All records, reports, test results or other documents concerning the medical care, treatment, and examination of the aforementioned person including consultation notes and records (even those by or from other medical providers);
2. Any and all prescription forms, records or lists;
3. Copies of all correspondence concerning the medical care, treatment, examination, or physical condition of the aforementioned person.
4. Copies of bills or statements of services rendered for such services, including any insurance claim forms and correspondence;
5. X-ray films, MRI films, CT films and all other imaging films, including reports of results of the imaging films.

I understand that the information in the patient's health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal confidentiality rules.

A copy of the consent and a notation as to any action taken thereon is to be entered in the patient's record. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the healthcare provider has taken action in reliance thereon. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

A photocopy of this authorization shall be considered as effective and valid as the original. In the absence of an express revocation, the authority granted under this authorization shall remain in effect **for one year from the date set forth below. This authorization does not waive my doctor/patient privilege.**

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS THE MEDICAL CARE AND/OR CONDITION OF THE ABOVE PARTY. This authorization is for securing the medical records and office notes only as described herein. This does not authorize the securing of a narrative medical report, nor does it authorize the bearer to conduct ex-parte interviews with any medical personnel regarding the treatments and condition. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.

The information requested by this authorization falls within § 164.512 of the Health Insurance Portability and Accountability Act of 1996.

The undersigned further agrees to waive at any time limitations required by the above provider with respect to their receipt of this authorization and the date on which the authorization was signed.

DATED: 7.9.2013

Kimberly Lancaster
SIGNATURE
PRINTED NAME: Kimberly Lancaster

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		$_____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Log #000011

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

July 16, 2013

Mr. Harmony Trevino
Stratos Legal Records, LLC
4299 San Felipe, Ste. 350
Houston, TX 77027

Re: Cain Seagraves

Dear Mr. Trevino:

Thank you for your courtesy in providing the HIPAA Compliant Authorization for Release of Medical Records. Enclosed as you requested is a Detailed Claims Report (DCR) for Mr. Cain Seagraves. The Department does not normally have clinical records; only information abstracted from provider claim forms. The DCR lists services billed to Medicaid and their Health Maintenance Organization (HMO) as well as the amount Medicaid or the HMO paid for services rendered from September1, 2008 through present. Depending upon the service, there may be a normal lag time of two (2) months or so before the claims show up. Also, providers normally have one (1) year from the date of service to bill.

In addition, I have forwarded a copy of your requests to the agency's Third Party Liability Department. Pursuant to Medicaid third party recovery rules, the Department of Health and Human Services has subrogation and assignment rights from the client, to the extent of the amount(s) paid on his/her behalf by Medicaid, to third party coverage. In the event that it is determined in this matter that there are Medicaid expenditures that are the responsibility of a liable third party, a summary of charges and payments, which are or appear to be related may be forwarded to the attorneys under separate cover.

Our expense for reproducing this claims information is thirty and 46/100 dollars ($30.46), which includes a minimum charge of twenty-five dollars for computer time. These documents are true and accurate printouts directly from computerized information kept in the normal course of Department business. Please make the check payable to the Department of Health and Human Services and send it to:

Department of Health and Human Services
Department of Receivables
Post Office Box 8297
Columbia, SC 29202-8297

I hope this information is helpful to you. Please contact me if there are any questions.

Sincerely,

Linda Hillian

Linda Hillian
Paralegal

/h
Enclosure
cc: Lynette Wilson, Receivables (w/o enclosures)