ORTHOGEORGIA
Orthopaedic Specialists®

Dear Patient:

Thank you for contacting **OrthoGeorgia** Medical Records Department. To better serve you with your request for medical records, **OrthoGeorgia** has partnered with Sharecare Health Data Services.

Sharecare Health Data Services will fulfill your request for records in a safe, secure, and timely manner.

In order to receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting they be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. For records to be delivered to another doctor, please choose fax or mail. Please select only one option. *The fax delivery option may only be used for records going to a doctor.* ***Please mail/email/fax/drop-off the completed Authorization form to*** **OrthoGeorgia.**

If you choose to fax your request, please fax to: 478-741-9657 or you can email the completed form to us at **medicalrecords@orthoga.org**

If you choose to mail request, please send to the OrthoGeorgia Office where you are seen.

For Records being sent to Another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling: **1-858-244-1811.**

Thank you,

Medical Records Supervisor
OrthoGeorgia

sharecare | HEALTH DATA SERVICES
Formerly BACTES

OrthoGeorgia Orthopaedic Specialists®
(P) 478-745-4206 (F) 478-254-5465

Authorization to Disclose Protected Health Information

The undersigned authorizes:

OrthoGeorgia Orthopaedic Specialists

to release my health information as noted below:

Patient Information

Patient Full Name: ______________________________ **Other Names?** ____________________

Patient Address: ____________________________________ **Date of Birth:** ____________________

City: ____________________ State: _____ Zip: ____________Phone #: ______________________

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on Sharecare HDS portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Sharecare.com containing instructions for accessing the records. There may be a fee for collecting your records.If so, an invoice will be provided to you through email or mail.

Name/Facility: ______________________________ **Attention:** ________________________

Address: ____________________________________ **Phone:** ________________________

City: __________________ State: _____ Zip: _________ **Fax #:** ______________________

Purpose of Request: ___ Personal ___ Treatment ___Legal ___Insurance ___Transfer ___Other:____________

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

___Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**: ______________________________:

☐ Progress Notes ☐ Radiology Reports ☐ Labs
☐ Operative Reports ☐ Injections ☐ Physical Therapy
☐Billing Statement ☐ Other: ________________

___**Radiology Disc**

(**Please pick ONE delivery option**)

[ ] Send by Email [ ] Records on CD	[ ] Fax to Doctor [ ] Mail Records	[ ] Records on Paper [ ] Pick up at Northside

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Georgia State law. *Records being sent to another healthcare provider will be sent at **no** cost.*

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _________(*Please Initial*)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**_____________ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

Signature*:____**Date:** _______________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

OrthoGeorgia Orthopaedic Specialists

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OrthoGeorgia Orthopaedic Specialists

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Patient Information

Patient Full N

PATIENT INFO HERE

Patient Addres

City: ___ ___

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

YOUR EMAIL HERE

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on Sharecare HDS portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Sharecare.com containing instructions for accessing the records. There may be a fee for collecting your records.If so, an invoice will be provided to you through email or mail.

Name/Facility:___

WHERE ARE YOUR RECORDS GOING? COMPLETE ALL SECTIONS

Address:___

City: ___ State: ___ Zip: ___ **Fax #:** ___

Purpose of Request: Personal___ Treatment___ Legal___ Insurance___ Transfer___ C

PICK ONE

Information to be Released

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___Please (office notes, l

___**Date R**___:

□ Prog

□ Oper ...erapy

□Billing

___**Radiol**

WHAT RECORDS ARE NEEDED?

(Please pick ONE delivery option)

[ ] Send by Email [ ] Records on CD	[ ] Fax to Doctor [ ] Pick up at Northside	[ ] Mail Records [ ] Pick up at Forsyth St.

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PLACE A FUTURE DATE HERE. SUGGESTED: ONE MONTH FROM TODAY

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:___________ ...e: ___________

SIGN AND DATE

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