

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/fax/drop-off the completed Authorization form to OrthoGeorgia.*

If you choose to fax your request, please fax to: **478-254-5465**

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:

**1-877-550-2083.**

Thank you,

Medical Records Supervisor  
**OrthoGeorgia**



**Patient Information**

Patient Full Name: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_  
 City: \_\_\_\_\_

PATIENT INFO HERE

**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: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

WHERE ARE YOUR RECORDS GOING?  
COMPLETE ALL SECTIONS

Purpose of Request: Personal Treatment Legal Insurance Transfer **PICK ONE**

**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 (in \_\_\_\_\_) **Please pick ONE delivery option**

WHAT RECORDS ARE NEEDED?

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Send by Email | <input type="checkbox"/> Fax to Doctor        | <input type="checkbox"/> Mail Records           |
| <input type="checkbox"/> Records on CD | <input type="checkbox"/> Pick up at Northside | <input type="checkbox"/> Pick up at Forsyth St. |

\_\_\_\_\_ (office)  
 \_\_\_\_\_ (therapy)  
 \_\_\_\_\_

Date Received: \_\_\_\_\_

Program \_\_\_\_\_  
 Operative \_\_\_\_\_  
 Billing \_\_\_\_\_  
 Radiology \_\_\_\_\_

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 until I receive the revocation. **Unless otherwise revoked, this authorization will expire on \_\_\_\_\_** *If I do not specify expiration this authorization will expire in 90 days.*

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

\_\_\_\_\_ If I do not have a health plan or health care provider, the released information may no longer be covered by the 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.

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\*: \_\_\_\_\_ **SIGN AND 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.