# Authorization to Disclose Protected Health Information

The undersigned authorizes to release my health information as noted below:

**Chatham Orthopaedic Associates**
**4425 Paulsen Street • Savannah, GA 31405**
**Ph (912) 355-6615 option #8**
**Fax (855) 645-0468**

CHATHAM ORTHOPAEDIC ASSOCIATES

**Effingham Health System Orthopaedics/Chatham Orthopaedic Associates Ortho Division**
**613 Towne Park Drive West Ste 303-304 • Rincon, GA 31326**
**Ph (912) 355-6615 option #8**
**Fax (855) 645-0468**

## Patient Information

**Patient Full Name:** _____ **Date of Birth:** _____

Patient Address: _____ **Other Names?** _____

City: _____ State: _____ Zip: _____ Phone #: _____

## Release Information To

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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You must provide a valid email address of your designated recipient if electronic delivery is chosen.

**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, 1 year of records will be provided.***

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Radiology Reports ☐ Radiology Images

Specify Date(s) of Service: _____

☐ **Entire Chart**
☐ **Other** (please specify):

_____

***Questions about your request or invoice can be answered by calling: Sharecare Health Data Services 1-866-967-0133***

**Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.**
**At no time will the cost-based fees exceed GA Law**
**I understand I will be responsible for the charges incurred in the release of my protected health information.**

***Rates are determined by Delivery Method Selected.***
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

| DELIVERY METHOD | [ ] Send by Email* | [ ] Mail Records on CD | [ ] Mail Records on Paper |
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**A valid email must be provided above. If you do not select a delivery method, Sharecare HDS will determine the delivery method based on the information provided on this form.* **No charge** for records being released to another healthcare provider.

## 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:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. 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.*
4. 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.
5. 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*:**_____ **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.*