Dear Patient:

Thank you for contacting **Resurgens Orthopaedics** Medical Records Department. To better serve you with your request for medical records, **Resurgens Orthopaedics** has partnered with Sharecare Health Data Services. Sharecare Health Data Services will fulfill your request for records in a safe, secure, and timely manner.

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.*

For Records being sent to Another Health Care Provider

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

This form can be dropped off at any of the Resurgens Orthopaedics locations or mailed to:

Resurgens Centralized Medical Records
270 Chastain Road
Kennesaw, GA 30144

Should you choose to fax your completed Authorization, please include a copy of your Driver's License and fax to: **404-215-2063**

Questions? Please contact a Sharecare Health Data Services representative by calling:
866-967-0133.

Thank you,

Medical Records Supervisor
Resurgens Orthopaedics

RESURGENS PC ORTHOPAEDICS
REACH for MORE

RELEASE OF INFORMATION AUTHORIZATION
Resurgens Centralized Medical Records
270 Chastain Road
Kennesaw, GA 30144 | Fax 404-215-2063

Please Print

The undersigned authorizes Resurgens Orthopaedics to release my health information as noted below.

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ **Date of Birth:** _____

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

Where would you like information released to:

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

You must provide a valid email address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on Sharecare Mail Express 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.

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
□ Radiology Disc □ Occupational Therapy
□ Billing Statements □ Other: _____

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 sent to another healthcare provider will be sent at **no** cost.*

Questions? Please contact:
Sharecare HDS at 866.967.0133

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 carefully filled out this form in its entirety. If incomplete, we may not be able to fulfill the 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.*

For Staff Use Only. ☐ **Check here if you completed all or a part of request in-house. If partial completion: please list completed item:**
_____