

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.

While faxing is the preferred method when returning the completed Authorization, it can also be dropped off at any of the Resurgens Orthopaedics' locations or mailed to:

Resurgens Centralized Medical Records 5671 Peachtree Dunwoody, Suite 700 Atlanta, GA 30342

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





RELEASE OF INFORMATION AUTHORIZATION

Resurgens Centralized Medical Records 5671 Peachtree Dunwoody Rd, Suite 700 Atlanta, GA 30342 | Fax 404-215-2063

Please Print																			
The undersigned authorizes Resurgens Orthopaedics to release my health information as noted below.																			
Patient Full Name:	Other Names?																		
							_		٠ ـ .										
	Date of Birth:																		
	State: Zip:						Phone #:												
Release Information To Email address for record delivery: Please ensure email address is legible!																			
Email address for record delive																			
You must provide a valid email address, eith	Der vour own	or that of	VOUR	designate	d reci	inient \	Vour re	acords wi	ll ha ı	provide	d as a	2 00	dobe	DDE fil	ا ا	n Sha	recare	Mail	
Express portal. If you do not retrieve your r	ecords within	30 days,	they v	will be del	eted.	You wil	ll recei	ve an em	ail fro	m Sha	recare								
1	e a fee for collecting your records. If so, an invoice will be provided to you through email. Attention:																		
	Phone:																		
City:	State: Zip: Fax #:																		
Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:																			
Information to be Released	(If you fo	il to sn	ecify	a 1 ve	ar al	hstraci	t will	he nro	vide	d)									
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 Pursuant to HIPAA 45 CFR, 164.524, we reserve the													е						
(includes most recent notes, labs, procedures & testing) 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																			
(office notes, labs, procedures & testing, up to 2 years) proportionally based on the cost. At no time will the										ne									
Date Range: cost-based fees exceed Georgia State law. Rec										cord	5								
□ Progress Notes □ Radiology R		sent to another healthcare provider will be sent at no cost.																	
□ Radiology Disc □ Occupation	injections Physical Therapy																		
□ Other:				Share							3								
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)														usc,					
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 as																		,	
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:																		
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^{*} 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.