Dear Patient,

Thank you for contacting **The Orthopedic Clinic** Release of Information Department. We are here to serve you and your health information needs.

**For FMLA or disability leave paperwork,** please complete the enclosed authorization form and attach your blank forms for completion.

- Please make sure you have *specific* instructions included as to where you are requesting the forms to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of The Orthopedic Clinic.
- You may elect to have completed forms emailed, mailed, or faxed to the recipient listed. **It is recommended that you elect to receive your forms back via email.**
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/disability leave claim.** This means records may be attached to the forms that are being completed and will be released as indicated on the authorization.

**A fee of $30.00 per form is required prior to form completion.** For updates regarding the same qualifying condition and claim, a $15.00 fee will be assessed per update. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider.

Once payment is received, your form will be completed and sent to the recipient listed on your release. For questions pertaining to FMLA or disability leave paperwork, please contact Sharecare Health Data Services at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of The Orthopedic Clinic

# Authorization to Disclose Protected Health Information

The undersigned authorizes

## Orthopedic Clinic of Daytona Beach

**Fax 386-254-6819**

to release my health information as noted below:

******All sections must be completed in order for request to be processed******

## Patient Information

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

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

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

## Release Information To (THIS SECTION MUST BE COMPLETED)

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

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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You must provide a valid email address and name 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 (THIS SECTION MUST BE COMPLETED)

***If you fail to specify, 1 year of records will be provided.***

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify Date(s) of Service: _____

☐ Entire Chart

☐ Radiology Images on a CD

☐ **Other** (please specify):

_____

***Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at (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 NC law (Statute: §44-115-80 )**

**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 |
|---|---|---|---|

**A valid email must be provided above. If you do not select a delivery method, Sharecare 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.*