



PEACHTREE ORTHOPEDICS

Patient Identification

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Street Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
City, State and Zip Code: \_\_\_\_\_
Email Address: \_\_\_\_\_

I request my records be provided: [ ] Paper(hard Copy) [ ] Email To Patient [ ] Fax to Physician's office
7-10 Business days 24-72 Business hours 24-48 Business hours
Email Address: \_\_\_\_\_ (Patient Only)
\*Electronic availability is subject to location and type of records for patient only.
\*Films cannot be provided electronically via email and are available for mail only.

Information is to be released by:

Information is to be sent to:

(Facility or Physician) \_\_\_\_\_ (Individual/Agency/Facility) \_\_\_\_\_
(Street Address) \_\_\_\_\_ (Street Address) \_\_\_\_\_
(City, State and Zip Code) \_\_\_\_\_ (City, State and Zip Code) \_\_\_\_\_
(Telephone Number) \_\_\_\_\_ (Telephone Number) \_\_\_\_\_

Information To Be Released – Covering the Periods of Health Care

(Fax Number) \_\_\_\_\_

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Please check type of information to be released:

Table with 3 columns: Complete Health Record, Office Notes Only, Physical Therapy Notes, Itemized Billing Statement, Radiology Reports Only, X-ray & MRI CD Only, Other (specify)

Purpose of Request

Table with 3 columns: Treatment or consultation, At the request of the patient, Billing or claims payment, Other (specify)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: [ ] Yes [ ] No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. Check One: [ ] Yes [ ] No

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event \_\_\_\_\_, or 90 days from date of signature, unless otherwise specified.

Re-release

I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Records sent to another physician will be processed at no charge to the patient. The charge for all other requests is as follows: \$0.90 flat labor fee and \$0.05 per page, in addition to postage and taxes. Requests delivered electronically: \$6.50 flat rate. Diagnostic Copying Costs: X-ray \$10.00 MRI \$20.00 All Requests for Information will be fulfilled by Ciox Health. Payment questions should be directed to Ciox Health at 1-800-367-1500. General Request questions: 404-425-1104. By signing below, you authorize your provider, identified above, to release your protected health information specified above. You may fax your request to: 404-355-2136 or 855-270-3558

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authority to Sign - if not patient: \_\_\_\_\_