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
	7-14 Business days	24-72 Business hours	24-48 Business hours

Email Address: _____ (**Patient Delivery Only**)

PEACHTREE ORTHOPEDICS FACILITIES (Select)

- ☐ Peachtree Orthopedics Clinics
- ☐ Peachtree Orthopedics Occupational Medicine
- ☐ Peachtree Orthopedics Physical Therapy
- ☐ Peachtree Orthopedics Surgery Center- Perimeter
- ☐ Peachtree Orthopedics Surgery Center - Piedmont

Information is to be Released to:

Name/Facility: _____Attention:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____ Fax:_____

Purpose of Request: ☐ My Personal Records ☐ Attorney ☐ Disability ☐ Insurance ☐ Continuation of Care

Information to be Released *(If you fail to specify, a 1-year abstract of records will be provided)*

From (date)_____To (date) _____

Please check type of information to be released:

- ☐ **Complete Health Records *(includes most recent notes, labs, procedure & testing*)**
- ☐ **Office Notes**
- ☐ **Radiology Reports**
- ☐ **Labs**
- ☐ **Operative Reports**
- ☐ **Injections**
- ☐ **Physical Therapy**
- ☐ **Occupational Therapy**
- ☐ **Radiology Disc *(Films cannot be provided electronically via email and are available for mail only.)***
- ☐ **Billing Statements**
- ☐ **Other**_____

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

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS Information. ***If you do not agree select No:*** ☐ ***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 in 90 days from date of signature.

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: _____

Authority to Sign - if not patient: _____

**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.*

PEACHTREE ORTHOPEDICS

Dear Patient

Thank you for choosing **Peachtree Orthopedics.**

To better serve you with your request for medical records, Peachtree Orthopedics has partnered with the copy service Providerflow. Providerflow 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 delivered.

If the records need to be delivered directly to you please select either mail or email.

For records to be delivered to another physician, please choose fax or mail.

Please note that the fax delivery option is only available if records are being sent to a physician.

Pursuant to HIPAA 45CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing copies of records. At no time will the cost-based fees exceed Georgia State Law. Records sent to another healthcare provider will be sent at no cost. Requests delivered electronically: $6.50 flat rate. Diagnostic Copying Costs: X-ray $10.00 MRI $20.00. All Requests for Information will be fulfilled through our copy service, Providerflow. Payment questions should be directed to **Providerflow at 1-888-635-6955.**

This form can be dropped off at any Peachtree Orthopedics location or mailed to:

Peachtree Orthopedics
2001 Peachtree Rd NE
Suite 705
Atlanta, GA 30309

Should you choose to fax your completed Authorization, please include a copy of your Driver's License or State issued ID and fax to: **404-355-2136 or 855-270-3558.**

If you have any questions please contact Peachtree Orthopedics Medical Records Department at **404-425-1104.**

Thank You,
Medical Records Staff
Peachtree Orthopedics