



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 (7-14-days) Email to Patient (24-48 hours) Fax to Physician (24-48 hours)
Email Address: _____ **(Patient Only)**

PEACHTREE ORTHOPEDICS FACILITIES (Select)

- Peachtree Orthopedics Clinic
- 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:

- Billing Statements**
- Complete Health Records** *(includes most recent notes, labs, procedure & testing)*
- Injections**
- Labs**
- Office Notes**
- Operative Reports**
- Occupational Therapy**
- Physical Therapy**
- Radiology Reports**
- Radiology** *(Films will be delivered electronically via email at no charge for patients only)*
- Same day radiology disc pick-up**
- 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: _____



PEACHTREE ORTHOPEDICS

**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.*

Dear Patient

Thank you for choosing **Peachtree Orthopedics Medical Records Department**. To better serve you with your request for medical records, Peachtree Orthopedics has partnered with 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. Records that need to be delivered directly to you, please choose mail or email. For records to be delivered to another physician, please choose fax or mail. The fax delivery option may only be used for records going to a physician.

Pursuit to HIPAA 45CFR, 164.524, We reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. 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 Provider Flow. Payment questions should be directed to **ProviderFlow at 1-888-635-6955**.

This form can be dropped off at any of the 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**

Questions? Please contact Peachtree Orthopedics Medical Records Department by calling: **404-425-1104**.

Thank You,
Medical Records Department
Peachtree Orthopedics