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| **Patient Information** | |
| Patient Full Name: | Account #: |
| Address: | Date of Birth: |
| City: State: Zip: | Social Security #: |

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| **Release Information To** | |
| *This box must be complete in order for request to be processed* | |
| Name/Facility: | Attention: |
| Address: | Phone: |
| City: State: Zip: | Fax: |
| Purpose of Request  🞏Personal 🞏Treatment 🞏 Legal 🞏Insurance 🞏Disability 🞏Transfer/Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Information to Be Released** |
| I, name listed above, do hereby request the following medical records on behalf of Piedmont Orthopaedic Complex to be sent to me. Piedmont Orthopaedic Complex has hired BACTES to handle the Release of Information Process. BACTES will send me an Invoice for prepayment of any charges I owe for records. A response will be sent within 30 days of receipt of this request when mailed to the address listed below. Chose between 3 options:  (*Option 1*) Mini Record Abstract - up to 40 pages - $20.00 plus postage (*Option 2*) 2 year abstract 40-100 pages - $35.00 plus postage (*Option 3*) Full record – GA state statutes plus postage  **Return this form to:**  Piedmont Orthopaedic Complex, 4660 Riverside Park Blvd., Macon, Ga. 31210 - Fax: 478-474-8001  I request copies of the following (please initial the chosen option):  \_\_\_\_\_\_\_\_Option 1 \_\_\_\_\_\_\_\_\_ Option 2 \_\_\_\_\_\_\_\_\_\_\_ Option 3  \_\_\_\_\_\_\_\_Specific Dates of Service (Option 4): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Month/Date/Year) |

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| **Authorization to Release Protected** |
| If applicable, I also give permission for the following to be disclosed:  - Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)  - Behavioral Health Services/Psychiatric Care  - Treatment for Alcohol and/or Drug Abuse |

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)*

* This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.
* I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
* I understand that my treatment or continued treatment by Piedmont Orthopaedic Complex and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
* I understand that I may inspect or copy the information that is used or disclosed.