RESURGENS PC ORTHOPAEDICS

AUTHORIZATION FOR RECORDS RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________________

Maiden/Other Name: ______________________ MRN (if known): ______________________

Address: ______________________ Phone Number: ______________________

City: ______________________ State: __________ Zip Code: ______________

1. RECEIVING PARTY & DELIVERY METHOD - CHOOSE ONE:

☐ Mail the records/information to me (see fee below).

☐ Deliver the records to my email electronically (see fee below).

Email: ______________________

☐ Release the records to (physician name if for medical care): ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: ______________

Phone: ______________________ Fax Number: ______________________

2. PURPOSE OF RELEASE/DISCLOSURE- CHOOSE ONE:

☐ My personal records ☐ Attorney

☐ Medical Care/Second Opinion ☐ Disability

☐ Other: ______________________

3. DESCRIPTION OF HEALTH INFORMATION/RECORDS TO BE DISCLOSED- CHOOSE ONE:

☐ Send complete medical record *without* X-ray/Films (CD). ☐ Send complete medical record *with* X-ray/Films (CD)

☐ Send partial medical records: Specify dates of service: From: ______________ To: ______________

☐ Send specific section circled below: Specify dates of service: From: ______________ To: ______________

History and Physical	X-rays/Films (CD)	Consultations	MRI Report
Discharge Summary	Rehabilitation	Office Notes	Lab Results
Operative Reports	Other: ______________		

☐ ***You must check this box if you are also requesting billing records***

4. EXPIRATION, REVOCATION OF AUTHORIZATION, & RE-DISCLOSURE

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization has no expiration date. When my health information is released pursuant to a valid authorization, the information released may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

5. FEE FOR RECORDS

Federal and state laws allow a fee to be charged for copying patient records and I will be responsible for the payment of such fees, unless the records are sent directly to a physician or healthcare facility. Patient copy fees vary based upon federal and state law, which take into account the expenditure to produce the requested documents.

6. RELEASE AND WAIVER

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, chemical dependency/alcohol abuse, communicable or infectious diseases (ie. AIDS, HIV, ARC, TB, and hepatitis). I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Resurgens, each of the Resurgens offices and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above. In cases where someone other than the patient executes the authorization, I understand documentation may be required to support the disclosure of personal health information as required by state and federal law. In most cases, records are processed within seven days. Please be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records.

______________________ ______________________

Signature of Patient/Legal Representative Date

______________________ ______________________

Printed Name Relationship to Patient

Fax requests to: 404-215-2063. Mail request to: Resurgens Centralized Medical Records
270 Chastain Rd, Kennesaw GA 30144 Phone: 678-594-6100

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke your authorization for the release of protected health information. To do so, you must complete the section below OR send us a written letter revoking your authorization. The revocation should be mailed to:

Resurgens, P.C.
Medical Information Services - Release of Information
5671 Peachtree Dunwoody Road, Suite 700
Atlanta, GA 30342

REVOCATION OF AUTHORIZATION

Patient Name: ____

Date of Birth: ____

Address: ____

____

I, ____, wish to revoke my authorization for the release of

protected health information to:____

(Person or place records should **not** be sent)

I realize that in the event that these records have *already* been released by valid authorization that the records cannot be retracted.

Signature of Patient/Legal Representative: ____ Date: _____________

Printed name (if not signed by the patient): ____

Relationship to Patient: ____