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) 7-10 Business days ☐ Email To Patient 24-72 Business hours ☐ Fax to Physician's office 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:

_____
(Facility or Physician)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(TelephoneNumber)

Information is to be sent to:

_____
(Individual/Agency/Facility)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Telephone Number)

_____
(Fax Number)

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ 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

☐ Treatmentorconsultation	☐ 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: _____