optim medical center
SCREVEN

Authorization to Disclose Protected Health Information
The undersigned authorizes
Optim Medical Center-Screven
215 Mims Road, Sylvania, GA 30467
Fax: 912.564.2997, **Email:** medicalrecordsscreven@optimhealth.com
to release my health information as noted below:

Patient Information

Patient Full Name: ____ **Date of Birth:** _____________________

Patient Address: ____ **Other Names?** ________________________

City: _______________________________ State: ______ Zip: _________ Phone #: ________________________

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address of your designated recipient if electronic delivery is chosen.

Name/Facility: ____ **Attention:** __________________________

Address: ____ **Phone:** _____________________

City: ____________________________ State: ______ Zip: ________ **Fax #:** __________________________

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:________________

Information to be Released

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports

Specify Date(s) of Service: ______________________________

☐ **Entire Chart**
☐ **Other** (please specify):

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Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at (866) 967-0133

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.
At no time will the cost-based fees exceed GA Law
I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

DELIVERY METHOD	☐ **Send by Email***	☐ **Mail Records on CD**	☐ **Mail Records on Paper**	☐ **Fax**	☐ **Patient Pickup**

**A valid email must be provided. If you do not select a delivery method, Sharecare HDS will determine the delivery method based on the information provided on this form.* No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* __________ (*Please Initial*)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ___________________________. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

Signature*:____ **Date:** ______________________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. 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.*