optimhealth | SYSTEM

AUTHORIZATION FOR PAIN MANAGEMENT, NEUROSURGERY AND THERAPY

THIS FORM MUST BE COMPLETED ENTIRELY.

Authorization to Disclose Protected Health Information
The undersigned authorizes
Optim Health System
210 E Derenne Ave • Savannah GA 31405
Fax: 912-721-2092 • Email: recordsrequest@optimhealth.com
to release my health information as noted below:

Patient Information *(This section must be completed in its entirety.)*

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Other Names?** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To *(This section must be completed in its entirety, even if records are for patient. If minor, parent/guardian must complete.)*

Email address for record delivery: *Please ensure the recipient's email address is legible & valid. (Individuals must be on your HIPAA on file with Optim.)*

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.)*

☐ Pain Management ☐ Neurosurgery ☐ Therapy

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostics - Reports Only*

Specify Date(s) of Service (MM/DD/YY):_____

☐ Entire Chart
☐ Other (please specify):

_____

_____

_____

***For diagnostic images, please contact the imaging department of the location where the images were taken. These are not processed through the records department.**

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. No Cash.

DELIVERY METHOD	[ ] Send by Email *Provide Above	[ ] Mail Records on CD	[ ] Mail Records on Paper	[ ] Fax	[ ] Patient Pickup**

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 released to another healthcare provider.
*A valid email must be provided.
****Records over 10 pages are billable. They must be mailed or emailed and cannot be picked up on-site. If you need to pick up records 10 pages or less, pickup will be coordinated if in the Savannah area.**

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, only if you agree to the release of such records*)**

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. Only complete if you wish to extend.*)**
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:** _____

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

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form and must also be on the HIPAA with Optim Health System. 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.**