Authorization to Release Protected Health Information

The undersigned authorizes
ORTHOVIRGINIA
250 S Main Street, Suite 224A • Blacksburg, VA 24060-4726
Fax: 540-552-7143 EMAIL: OVWMedicalRecords@orthovirginia.com
to release my health information as noted below:

*****All sections must be completed for request to be processed*****

PATIENT Information [required]

Patient's Full Name

Address

City, State, Zip Code

Date of Birth Phone (Home or Cell)

RELEASE Information To [required]

Name of person, provider, attorney, etc.

Address

City, State, Zip Code

Phone Fax

Email

PURPOSE: ☐ Patient ☐ Legal ☐ Insurance ☐ Continuing Care ☐ Other_____

INFORMATION TO BE RELEASED [required] If you fail to specify, 1 year of records will be provided.

☐ Service Date Range:_____Body Part:_____

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy ☐ Other (specify): _____

DELIVERY METHOD ☐ Paper (mail) ☐ CD (mail) ☐ Fax ☐ Email ☐ MyChart

☐ Radiology Images (flat fee)

DELIVERY METHOD ☐ CD (mail) ☐ Email

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 Below

PAYMENT OPTIONS: Check, Credit Card, or Money Order

No charge for records being released to another healthcare provider

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION [required]

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.

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* (required)	Printed Name of Person Signing	Date Signed (required)

*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.

Questions about your request or invoice can be answered by calling Sharecare: Medical Record Requests 877-270-4365

Dear Patient:

Sharecare HDS, a trusted Business Associate of ***OrthoVirginia***, is happy to assist you in your request for a copy of your medical record.

The cost for the reproduction of medical records is quite extensive. In addition, HIPAA (Federal Privacy Act) requires covered entities to track and report each request. Because of this, ***OrthoVirginia*** has contracted with ***Sharecare HDS*** to fulfill the requests for copies of records that come in each day from doctors' offices, attorneys, insurance companies and from patients like you. **Only *OrthoVirginia*** records will be released.

Therefore, in order to fulfill your request, ***Sharecare HDS*** reserves the right to charge a reasonable cost-based fee for producing and delivering the copies. The fees are Pursuant to HIPAA 45 CFR, 164.524 and at no time will the cost based fee exceed VA law (Statues §8.01-413).

This upfront fee must be remitted by Check, Cash, Credit Card or Money Order with the Invoice stub to ***Sharecare HDS*** only. Please do not remit payment to ***OrthoVirginia***.

Sharecare HDS is able to provide you with a copy of your medical records by Email, CD or Paper.

You will receive an invoice by USPS mail. Your request will be fulfilled upon payment of that invoice. Should you have any questions, please contact ***Sharecare HDS*** at (877) 270-4365.

Sincerely,

OrthoVirginia
Medical Records Department