Tidewater Orthopaedics
Specialized Care You Can Trust

Authorization to Disclose Protected Health Information

The undersigned authorizes:

Tidewater Orthopaedics
901 Enterprise Parkway, Suite 900 • Hampton, Virginia 23666
Fax: 757-827-2566

to release my health information as noted below.

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

Patient Information

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

Patient Address: _______________ Other Names? _______________

City: _______________ State: ______ Zip: __________ Phone #: _______________

Release Information To (THIS SECTION MUST BE COMPLETED)

Name/Facility: _______________ **Attention:** _______________

Address: _______________ **Phone:** _______________

City: _______________ State: ______ Zip: ________ **Fax**: _______________

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

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

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

Information to be Released (THIS SECTION MUST BE COMPLETED)

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

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify Date(s) of Service: _______________

☐ **Entire Chart**

☐ **Images on Disc** (please allow 7-10 business days for processing)

*Body Part:*_______________

☐ **Other** (please specify):

____

Questions about your request or invoice can be answered by calling: SHARECARE HDS at (877) 270-4365

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 VA law (Statute: §8.01-413)

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**

A valid email must be provided above. 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 (excluding radiology images) 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.*