

REQUEST FOR MEDICAL RECORDS

Midlands Orthopaedics & Neurosurgery has partnered with Sharecare to fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, complete and return the attached Authorization form including *specific* instructions as to **what** records you are requesting and **where** you are requesting records to be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email.

Please fax the completed form with a copy of your driver's license or state issued ID to (866) 920-3647

For Records being sent to another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

For fastest service, you may also submit requests using our Online Patient Request Form by scanning the QR code below:



You can contact a Sharecare Health Data Services representative at any time by calling:

858-244-1811





Authorization to Disclose Protected Health Information The undersigned authorizes

Midlands Orthopaedics & Neurosurgery 1910 Blanding Street, Columbia, SC, 29201 (P) (803)256-4107 (F) (866)920-3647 to release my health information as noted below:

| Patient Information | | | |
|--|--------------------------------|--|----|
| Patient Full Name: | | Other Names? | |
| Patient Address: | | Date of Birth: | |
| City: | State: Zip: | Phone #: | |
| Release Information To | | | |
| Email address for record delivery: | Please ensure email address is | s legible! | |
| | | | |
| If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail. | | | |
| Name/Facility: | _ | Attention: | |
| Address: | | Phone: | |
| City: S | state: Zip: | Fax #: | |
| Purpose of Request: Personal | TreatmentLega | alInsuranceTransferOther: | _ |
| Information to be Released | | If you fail to specify, a 1-year abstract will be provided. | |
| Please release a 1-year abstra most recent notes, labs, proced | • | (Please pick ONE delivery option) | |
| Please release a 2-year abstra notes, labs, procedures & testir | | [] Send by Email [] Fax to Doctor [] Records on Paper [] Records on CD | er |
| Date Range: | : | Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to | |
| □ Progress Notes □ Radiology R □ Operative Reports □ Injection □ Other: | ns Physical Therapy | charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the | II |
| | | cost-based fees exceed South Carolina Statute: (44-7-325) | |
| Authorization to Release Protec | | | |
| I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, | | | |
| psychiatric, HIV testing, HIV resu | ults, or AIDS information | .*(Please Initial) | |
| I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 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: | | | |
| 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.