

Please Select clinic



**Athens Orthopedic Clinic / Athens B & J**  
**1765 Old West Broad St., Bldg 2, Ste 200**  
**Athens, GA 30606**

**Request for Access To and**  
**Authorization for Use and Disclosure of**  
**Protected Health Information**

**Patient Identification**

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State ZIP: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Tel # (cell): \_\_\_\_\_  
Tel # (home): \_\_\_\_\_  
Tel # (work): \_\_\_\_\_

**Prepayment is required before record request is processed (Records/Bills \$6.50 – Radiology disc \$10.00) Call ResolveROI to make payment: at 844-887-8109**

**I request my records to be delivered by:**  Electronic Delivery  Mail (paper)  Picked Up (paper)  Fax to Healthcare Provider  
*\*Films cannot be provided electronically and are available on a disc and for mail or pick-up only*

**I hereby authorize Athens Orthopedic Clinic to Disclose my Protected Health Information to:**

Facility/Individual Name: \_\_\_\_\_  
Attention: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State ZIP: \_\_\_\_\_

Relationship: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Tel #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Information Be Released for TREATMENT DATES: From (date): \_\_\_\_\_ To (date): \_\_\_\_\_**

**TYPE OF INFORMATION TO BE RELEASED:**

- Office Notes Only
- Physical Therapy Notes
- Itemized Billing Statement
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Radiology Reports Only
- Complete Health Record
- X-ray or MRI (disc only)
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**PURPOSE OF THE REQUEST for PHI DISCLOSURE:**

- Treatment/Consultation
- Personal Request
- Insurance
- Legal (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records Release:**

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check one:**  Yes  No

**Time Limit & Right to Revoke Authorization:**

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorization disclosure. Unless revoked, this Authorization will expire on the following date or event \_\_\_\_\_, or 90 days from the date of signature, unless otherwise specified.

**Re-release:**

I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Cost of Records:**

The cost of copies of **medical records for your personal use is \$6.50 per request, and MRI/xray images are \$10 per disc, with payment due in advance.** Requests for continuing care and records provided directly to another healthcare provider will be at no cost, unless transferring to another healthcare provider, and all other requests will be billed at applicable rates. Please **contact ResolveROI at 844-887-8109 for questions** regarding your record request.

**Signature of Patient or Personal Representative Who May Request Disclosure**

By signing below, you authorize your healthcare provider identified above to release your protected health information, and acknowledge and understand the terms of this **Request for Access to and Authorization for Use and Disclosure of Protected Health Information.**

**Patient / Personal Representative signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Payment received by:** \_\_\_\_\_ **Method:** Cash: \_\_\_\_\_ Check \_\_\_\_\_ Credit: \_\_\_\_\_ **Total Payment \$:** \_\_\_\_\_