optimhealthcare

Authorization to Disclose Protected Health Information

The undersigned authorizes
Optim Healthcare
210 East DeRenne Ave.
Savannah, GA 31405
Ph. 912-644-5300 • Fx. 912-988-5065
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

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Email: _____ *(Patient's Only – Please ensure email address is legible!)*

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

Please forward Records by: ☐ Mail ☐ Fax (for Dr's Offices) ☐ Email (For Patients)

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year** abstract of my records (includes most recent notes, labs, & testing)
☐ Please release a **2 year** abstract of my records
☐ Please release my **entire record**.
☐ **Other** (please specify): _____
_____

I understand I will be responsible for the charges incurred in the release of my protected health information. *See GA Code §31-33-3*
Copy fee: $0.97 per page for pages 1-20
$0.83 per page for pages 21-100
$0.66 per page, thereafter + Postage, if applicable or
$25.00 flat fee for 2 year abstract
Records being sent to another healthcare provider will be provided at no cost. If you have any questions or need to check status of your request, please contact BACTES at 866-967-0133.

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.

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.*

Optim Healthcare is a collaboration between Optim Orthopedics, Optim Medical Center-Jenkins, Optim Medical Center-Screven, and the physician-owned Optim Medical Center-Tattnall.