COMPREHENSIVE ORTHOPAEDICS, S.C.

7401 104th Avenue Suite 110 Kenosha, WI 53142 Phone: 262-764-5595 Fax 262-764-9314

Authorization to use/or Disclose Personal Health Information
A copy of this authorization will have the same force and effect as the original

Patients Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I AUTHORIZE: Comprehensive Orthopaedics, S.C. To release my medical records, as specified below via mail or patient pick-up, to:

(Name & Address of Party you want **RECORDS RELEASED TO**)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Record Request may take up to 7-10 business days to process

INFORMATION TO BE RELEASED

All Medical Records:_____ (No other selection needs to be made if choosing all records)

Specify part of body:_____(Select from the below options)

____Clinical Chart Notes:____Lab/Pathology Reports:____Hospitalization:____Billing Records:____

____Diagnostic Reports Only (X-Ray, MRI/CT, EMG)____X-Ray Films:____Other:____All Records:____

For the following items to be included in the use or disclosure, in compliance with Wisconsin Statues, please release Records pertaining to: (Check all that apply)

Mental Health:___AIDS/HIV:___Genetic Testing:___Developmental Disabilities:____Drugs/Alcohol Abuse:____

PURPOSE OF THIS DISCLOSURE:

____Physician / Second Opinion:____Moving Relocation:____Attorney / Litigation:____Insurance Request: ____Other: _____

1) I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by this regulation. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
2) I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.
3) I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.
4) I understand I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, enrollment in a health plan, or eligibility for benefits.
5) There will be a charge for all records requested, except for continuity of care when we refer you to another doctor and we send those records to that doctor's office, otherwise copies will be charged by our copy service *Sharecare Health Data Services*. You will receive a pre-pay invoice directly from *Sharecare Health Data Services* for this service. You may pay this invoice via phone, mail or web in order to have your complete records released.

Signature of Patient / Legal Representative Date

_____

_____

Print Name Relationship

(Office Use Only)

Films to be released: _____

_____ *# of films:* _____ *Released by:* _____

If you are in need of Medical Records:

Please submit your request to your medical provider Comprehensive Orthopaedics, S.C.. Comprehensive Orthopaedics, S.C. and Sharecare Health Data Services, its Business Associate, have partnered to provide your requested information in a compliant and timely manner. In accordance with the established process, Comprehensive Orthopaedics, S.C. will forward the request to Sharecare Health Data Services for processing. Your records will be released in the format you requested within 72 hours *after* Sharecare Health Data Services receives your payment.

If you are a Patient or Patient Representative:

Your medical records are legal documents maintained by Comprehensive Orthopaedics, S.C.; you have a right to a copy of your medical information. Under federal and state law, we are allowed to recover certain costs related to making a copy of your medical records. If a fee applies to your request, you will receive an invoice after we determine the cost of processing your specific request. The fee we charge is cost-based and includes only the labor, materials and postage as allowed by HIPAA and highlighted by the Omnibus Final Rule.

The requested output method will impact the cost to you. For example, including labor, materials and postage, a 50-page record would cost approximately $12.50 if delivered via secure e-transmittal; $13.00 if printed on CD or paper and mailed using the postal service. The fee charged to patients will not exceed $25.00, plus delivery cost.

If you are a Third Party requesting patient records in accordance with HIPAA:

If a fee applies to your request, you will receive an invoice after we determine the cost of processing your specific request. The invoice can be paid, and the records can be accessed, through our secure website.

After Your Request is Processed:

To pay online:	https://payment.hds.sharecare.com/Payments/
To pay via mail:	Sharecare Health Data Services 8344 Clairemont Mesa Blvd, Ste 201 San Diego, CA 92111-1327
To pay via phone:	800-560-3800, Option 2
To sign up for e-Delivery:	https://payment.hds.sharecare.com/Accounts/Verify
To check the status of you request:	https://recordstatus.hds.sharecare.com/
If you need personal assistance:	800-560-3800, Option 2