Dear Valued Customer:

Thank you for contacting *East Alabama Medical Center* for your health care needs! We are happy to assist you in obtaining a copy of your medical record.

We have partnered with **Sharecare**, the leader in the release of information industry, to fulfill your medical records request. **Sharecare** is recognized for quality and excellent customer service to thousands of healthcare providers. You can be assured that they will complete your request for medical records in a safe, secure and timely manner.

To receive a copy of your medical records, we ask that you complete and return the attached Authorization form. Please make sure that you have *specific* instructions included 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*. For records to be delivered to your doctor, please choose *fax* or *mail*. Please select only one option. *The fax delivery option may only be used for records going to a doctor.*

Once you have completed the Authorization form, you may either ***mail, fax or drop-off*** it to us along with a copy of your Driver's License.

MAIL
East Alabama Medical Center
Attention: Medical Records/ROI
2000 Pepperell Parkway
Opelika, AL 36801

DROP-OFF
East Alabama Medical Center
Attention: Medical Records/ROI
122 North 20th Street, Building 28
Opelika, AL 36801

FAX
334-528-2243

For Records being sent to Another Health Care Provider
Please provide as much contact information as possible for your provider, including the address, phone and fax numbers.

You may contact a Sharecare representative at any time by calling **866-641-4778 or 334-528-2261.**

Thank you,

Medical Records Manager
East Alabama Medical Center

Authorization to Disclose Protected Health Information

The undersigned authorizes

EAST ALABAMA MEDICAL CENTER

2000 Pepperell Parkway ● Opelika, AL 36801 ● Phone: 334-528-2261 ● Fax: 334-528-2243

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:

E-mail address for record delivery: *Please ensure e-mail address is legible!*

You must provide a valid e-mail address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on **Sharecare** HDS Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an e-mail from **Sharecare.com** 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 e-mail.

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

Address: _____ **Phone:** _____

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

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

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, procedures & testing)

☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

☐ **Date Range**: _____

□ Progress Notes □ Radiology Reports □ Labs

□ Operative Reports □ Injections □ Physical Therapy

□ Other: _____

☐ **Radiology CD** _____

(Charge for CD may apply)

Rates are determined by Delivery Method Selected.

Price **Per** Page	**[ ] Send by Email***	**[ ] Records on CD**	**[ ] Records on Paper**

Copy Fee: Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed Alabama law (Section 12-21-6.1).

A valid e-mail 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 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. 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:** _____.

If I do not specify expiration this authorization will expire in 90 days. 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. 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, we may be unable to fulfill this request.

Signature:** _____ **Date:** _____

***For non-emancipated minors under the age of 19, 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.*

Example Sheet Only

Authorization to Disclose Protected Health Information

The undersigned authorizes

EAST ALABAMA MEDICAL CENTER

2000 Pepperell Parkway ● Opelika, AL 36801 ● Phone: 334-528-2261 ● Fax: 334-528-2243

to release my health information as noted below

Example Sheet Only

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

PATIENT INFO HERE

Release Information To:

E-mail address for record delivery: *Please ensure e-mail address is legible!*

EMAIL ADDRESS HERE

You must provide a valid e-mail address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on **Sharecare** HDS Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an e-mail from **Sharecare.com** 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 e-mail.

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

Address: _____

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

WHERE ARE THE RECORDS GOING?

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

WHY ARE THEY NEEDED?

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, procedures & testing)

☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

CHOOSE ONE

☐ **Date Range**: _____

☐ Progress Notes ☐ Radiology Reports ☐ Labs

☐ Operative Reports ☐ Injections ☐ Physical Therapy

☐ Other: _____

☐ **Radiology CD** _____

(Charge for CD may apply)

Rates are determined by Delivery Method Selected.

[ ] Per Page	[ ] Send by Email*	[ ] Records on CD	[ ] Records on Paper

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MUST COMPLETE—WHAT IS NEEDED?

and 3 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 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. 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:** _____.

If I do not specify expiration this authorization will expire in 90 days. 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. 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, we ma

SIGN & DATE

Signature:** _____ **Date:** _____

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