Dear Valued Customer:

Thank you for contacting *East Alabama Medical Center—Lanier* 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	**DROP-OFF**	**FAX**
East Alabama Medical Center—Lanier Attention: Medical Records/ROI 4800 49th Street Valley, AL 36854	**East Alabama Medical Center—Lanier** Attention: Medical Records/ROI 4800 49th Street Valley, AL 36854	**334-710-0137**

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 334-710-0135.**

Thank you,

Medical Records Manager
East Alabama Medical Center—Lanier

Authorization to Disclose Protected Health Information

The undersigned authorizes

EAST ALABAMA MEDICAL CENTER—LANIER

4800 49TH Street ● Valley, AL 36854 ● Phone: 334-710-0135 ● Fax: 334-710-0137

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—LANIER

4800 49TH Street ● Valley, AL 36854 ● Phone: 334-710-0135 ● Fax: 334-710-0137

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)

MUST COMPLETE—WHAT IS NEEDED?

Rates are determined by Delivery Method Selected.

[ ] 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 copies. At no time will the cost-based fees exceed Alabama [illegible] and 3 main 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[illegible]

SIGN & DATE

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.*