MEDICAL SPECIALISTS OF THE PALM BEACHES, INC.

Dear Patient:

Thank you for contacting **Medical Specialists of the Palm Beaches** Medical Records Department. To better serve you with your request for medical records, **Medical Specialists of the Palm Beaches** has partnered with Sharecare Health Data Services.

Sharecare Health Data Services will fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting they 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**.
  (PLEASE SELECT ONLY ONE OPTION)
- For records to be delivered to another 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 and must include a copy of your Driver's License.
- You may **Mail, Email or Fax the completed Authorization form to:**
  - **Mail:** Medical Specialists of the Palm Beaches, Inc.
    7593 W. Boynton Beach Blvd. #220
    Boynton Beach, FL. 33437
  - **Email:** mspbmedicalrecords@mspbhealth.com
  - **Fax:** 561-649-7028
  - You can give the authorization form to your doctor office and ask them to submit it interdepartmental or fax if the patient is unab*le to do the above*

For Records being sent to Another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling:

877-570-4335

Thank you,

Medical Specialists of the Palm Beaches, Inc.

sharecare | HEALTH DATA SERVICES

Patient Authorization

sharecare | HEALTH DATA SERVICES

Authorization to Disclose Protected Health Information

The undersigned authorizes:

Medical Specialists of the Palm Beaches

to release my health information as noted below:

1. Patient Information

Patient Full Name: _____ Other Names? _____

Patient Address: _____ Date of Birth: _____

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

2. Release Information To

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipiet. 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 email from hds.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 email or mail.

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

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

3. 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 (includes office notes, labs, procedures & testing, up to 2 years)

____ Date Range: _____

- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Labs
- ☐ Operative Reports
- ☐ Injections
- ☐ Physical Therapy
- ☐ Other: _____

____ Radiology Disc

4.

(Please pick **ONE** delivery option)

☐ Send by email ☐ Records on CD	☐ Fax to Doctor	☐ Records on Paper

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed _____ State law.

5. Authorization to Release Protected Health Information

I acknowledge and herby 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: 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 autorization 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.

6.

STOP **Please confirm 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 _____, a parent or guardian must sign release form. If patient is undable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

1. **Patient Information:** Ensure the patient fills out this entire portion with full name (along with any nicknames or previous names used), address, and DOB.
2. **Release Information To:** We need the full name and address of where the patient is wanting records sent and would need a fax number included to electronically send records to another doctor.
3. **Information to be Released:** The patient needs to make a selection as to what they are wanting released. If they do not make a selection, we default to sending a 1-year abstract of records.
4. **Delivery Option:** This option allows us to know exactly how the patient is wanting the records delivered, via: email, fax or paper copies.
5. **Authorization to Release Protected Health Information:** Only applicable to any sensitive information that may be in the chart. If this is not initialed, we will not include any of this info in the record set that is sent.
6. **Signature:** Unless records are being sent to doctor's office, the patient MUST sign and date the auth or it will not be processed. As a side note—The legal age for a child to sign a request is _____ in the state of _____. We would typically have to have a parent or guardian sign if they are not over this age limit.

Authorization to Disclose Protected Health Information

The undersigned authorizes:
MEDICAL SPECIALISTS OF THE PALM BEACHES
mspbmedicalrecords@mspbhealth.com
(P) (561) 649-7000 ext. 4211 (F) (561) 649-7028
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

Email address for record delivery: *Please ensure email address is legible!*

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email 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 email or 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 Disc**

(**Please pick ONE delivery option**)

[ ] Send by Email **[ ] Records on CD**	**[ ] Fax to Doctor**	**[ ] Records on Paper**

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Florida Statute: (395.3025(1))

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: 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.

STOP

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.*