

## Dear Patient:

Thank you for contacting **Pain Consultants of West Florida** Medical Records Department. To better serve you with your request for medical records, **Pain Consultants of West Florida** 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. 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. Please mail/fax/drop-off the completed Authorization form to Pain Consultants of West Florida

If you choose to fax your request, please fax to (850) 494-0001. Please include a copy of your Driver's License.

If you choose to mail request, please send to:
Pain Consultants of West Florida
Attention: Medical Records
4624 North Davis Highway
Pensacola, FL 32503

## 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:

(866) 967-0133

Thank you,

Medical Records Supervisor

Pain Consultants of West Florida





Authorization to Disclose Protected Health Information
The undersigned authorizes:
Pain Consultants of West Florida
4624 North Davis Highway, Pensacola, FL 32503
(P) (850) 494-0000 (F) (850) 494-0001
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 TreatmentLega	alInsuranceTransferOther:
Information to be Released  If you fail to specify, a 1-year abstract will be provided.	
Please release a <b>1-year abstract</b> of my records (includes most recent notes, labs, procedures & testing)	(Please pick ONE delivery option)
Please release a <b>2-year abstract</b> of my records (office notes, labs, procedures & testing, up to 2 years)	[ ] Send by Email [ ] Fax to Doctor [ ] Records on Paper [ ] Records on CD
Date Range::  □ Progress Notes □ Radiology Reports □ Labs □ Operative Reports □ Injections □ Physical Therapy □ Other:	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. <b>Unless otherwise revoked, this authorization will expire on the following date, event or condition:</b>	
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:

<sup>\*</sup> 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.