SAVA PODIATRY AND WELLNESS CENTERS

Adult & Children's Foot Care | Foot & Ankle Surgery | Sports Medicine | Regenerative Medicine

Patients requesting records: Please complete the Medical Records release authorization form at the bottom of this page. Please allow a minimum of 7 to 10 business days to process your forms. Please call 678-239-4204 with any questions.

Request for Access to, and Authorization for Use and Disclosure of Protected Health Information

PATIENT FIRST AND LAST NAME:_____

PATIENT ADDRESS:_____

PATIENT CITY, STATE, ZIP: _____

PATIENT EMAIL ADDRESS:_____

PATIENT DATE OF BIRTH:_____

CELL PHONE:_____HOME PHONE:_____

Record Delivery Method

I request my records to be delivered by: **(required)**
*Films cannot be provided electronically and are available on a disc and for mail or Patient pick-up only

○ Electronic Delivery ○ Mail (paper) ○ Picked-up (paper) ○ Fax to Healthcare Provider

Authorized Disclosure

I hereby authorize Sava Podiatry and Wellness Centers, its management company and subcontractors, to disclose my Protected Health Information to:

Facility/Individual Name: _____

Attention: _____

Street Address: _____

City, State and ZIP: _____

Relationship to patient: _____

Fax #: _____

Telephone #: _____

Email Address: _____

Information be released for TREATMENT DATES: **(required)**

- ○ All
- ○ Specify starting and ending dates: Specify starting and ending dates:

Type of Information to be Released: **(required)**

- ☐ Office Notes Only
- ☐ Physical Therapy Notes
- ☐ Itemized Billing Statement
- ☐ Radiology Reports Only
- ☐ Complete Health Record
- ☐ X-ray images
- ☐ Other:

Purpose of the Request for PHI Disclosure **(required)**

- ☐ Disability
- ☐ Insurance
- ☐ Legal
- ☐ Personal Request
- ☐ Treatment/Consultation
- ☐ Other:

Notice of understanding

Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records **(required)**
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

- ○ Yes ○ No

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorization disclosure. Unless revoked, this Authorization will expire on the following date or event, or 90 days from the date of signature, unless otherwise specified.

Re-release:

I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Cost of Records:

The cost of copies of **medical records for your personal use or anyone that is not a certified physician is $25.88 retrieval fee plus 0.97 per page (1-20), 0.83 per page (21-100), 0.66 per page over 100 (electronic only via email or fax) per request and MRI/X-Ray images are $25 per disc, with payment due in advance.** Requests for continuing care and records provided directly to another healthcare provider need to be requested by the certified treating physician (DO, MD, DPM, DDS, OD only), otherwise, you will be charged.

Signature of Patient or Personal Representative Who May Request Disclosure **(required)**

By signing below, you authorize your healthcare provider identified above to release your protected health information and acknowledge and understand the terms of this Request for Access to ad Authorization for Use and Discloser of Protected Health Information.

I hereby state that I am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records.

This form gives you, Sava Podiatry and Wellness Centers, LLC, permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

Signature:_____

PRINT: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

Your completed authorization form may be emailed to SavaPodiatry@gmail.com, or mailed to Sava Podiatry and Wellness Centers, 1675 Cumberland Pkwy SE, Suite 201, Smyrna, GA 30080