Pacific Rim ORTHOPAEDIC SURGEONS

(Outgoing Records)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: _____

Date of Birth: _____ SSN: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization. I understand that I have a right to receive a copy of this Authorization.

Requesting Records from:
Pacific Rim Orthopaedic Surgeons, PLLC
Attention: Medical Records
2979 Squalicum Parkway
Suite 203
Bellingham , WA, 98225
Phone: (360) 733-7670 Fax: (360) 647-1901

Where to send the records to:
Name/Facility: _____
Attention: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____ FAX: ( ) _____
☐ Check box if you prefer a CD.

Please send records from the following date range: from: _____ to: _____

☐ Labs ☐ History and Physical ☐ Consultation Notes
☐ Progress Notes ☐ Other: _____

Purpose of requested use or disclosure: ☐ Continuing Care ☐ Patient Request
☐ Insurance ☐ Legal ☐ Other _____

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information Initial if requesting: _____
☐ HIV test results Initial if requesting: _____
☐ Alcohol/drug treatment information Initial if requesting: _____

*If not checked and initialed, the records containing such information can NOT be released.

Duration: This Authorization expires [insert date]: _____
*If no Date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to PROS. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____

RECORD REQUEST

To obtain a copy of medical records, a request must be submitted to **Pacific Rim Orthopaedic Surgeons.**

Sharecare Health Data Services is the Release of Information Service for **Pacific Rim Orthopaedic Surgeons.** Once records have been copied you will receive an invoice from Sharecare.

When will the records be ready?

Records will be ready in 7-14 business days from the receipt of your request. You will receive an invoice as soon as records are ready.

How do I check Status?

Check Status of Records:

- Go to https://recordstatus.sharecare.com
- Or contact customer Service at 800-560-3800

How do I pay for the records?

To Pay Online:

- Go to https://payment.bactes.com/Payments
- Or Contact Customer Service at 800-560-3800

Additional Questions/ Live Chat?

Questions on how to obtain records:

- Call Customer Service at 800-560-3800

Live Chat:

- Go to https://hds.sharecare.com/services/patients
    - Orange pop up will appear on the left bottom corner. Click on it and it will open the chat option.