Dear Patient:

Thank you for contacting **Dr. Hussamy's** Medical Records Department. To better serve you with your request for medical records, **Dr. Hussamy** 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*** **Dr. Hussamy.**

**If you choose to fax your request, please fax to 772-213-9810.** Please include a copy of your Driver's License.

**If you choose to mail request, please send to:**
**Dr. Hussamy**
Attention: Medical Records
1260 37th Street, Suite 102
Vero Beach, Fl 32960

**<u>For Records being sent to Another Health Care Provider</u>**
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:

**877-548-4069**

Thank you,

Medical Records Supervisor
**Dr. Hussamy**

sharecare | HEALTH DATA SERVICES

**Authorization to Disclose Protected Health Information**
**The undersigned authorizes:**
**Dr. Hussamy**
**1260 37th Street, Suite 102, Vero Beach, FL 32960**
**(P) (772) 213-9800 (F) (772) 213-9810**
**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!*

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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<br>[ ] 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.

**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.*