Medical Records Request

Piedmont Orthopaedic Complex
4660 Riverside Park Blvd
Macon, GA 31210
Telephone: 478.474.2114 Fax: 478.474.8001

Patient Information			
Patient Full Name:			Account #:
Address:			Date of Birth:
City:	State:	Zip:	Email Address:

Release Information To			
This box must be complete in order for request to be processed			
Name/Facility:			Email Address:
Address:			Phone:
City:	State:	Zip:	Fax:

Purpose of Request
☐Personal ☐Treatment ☐ Legal ☐Insurance ☐Disability
☐Transfer/Reason:______________________ ☐Other:____________________________

Delivery Method
☐ Electronic Portal Access(specify email above) ☐ Fax ☐ Mail - Paper copies ☐Mail - CD

Information to Be Released

Dates of Service: From: _______________________ To: _________________________
☐Abstract/Pertinent Info ☐Operative Report ☐ Office Notes ☐Imaging/Lab/Pathology Reports
☐Complete Chart ☐Itemized Billing Statement ☐Other:___________________________

Authorization to Release Protected

If applicable, I also give permission for the following to be disclosed:
- Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- Behavioral Health Services/Psychiatric Care
- Treatment for Alcohol and/or Drug Abuse

Patient's Signature: ____ Date: _________________________

Signature of Parent or Legal Guardian: ____________________________________ Date: _________________________

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Piedmont Orthopaedic Complex and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.