Authorization to Disclose Protected Health Information

The undersigned authorizes



to release my health information as noted below:

All sections must be completed in order for request to be processed

| Patient Information | | | | | | |
|--|---|--|--|--|--|--|
| Patient Full Name: | Date of Birth: | | | | | |
| Patient Address: | Other Names? | | | | | |
| City: State: | Zip: Phone #: | | | | | |
| Release Information To (THIS SECTION MUST BE COMPLETED) | | | | | | |
| Email address for record delivery: Please ensure email addr | ress is legible! | | | | | |
| You must provide a valid email address and name of your designated recipient i | felectronic delivery is chosen. | | | | | |
| Name/Facility: Attention: | | | | | | |
| Address: | Phone: | | | | | |
| City: State: | _ Zip: Fax #: | | | | | |
| Purpose of Request: Personal Treatment Legal Insurance Transfer Other: | | | | | | |
| Information to be Released (THIS SECTION MUST BE COMPLETE | D) If you fail to specify, 1 year of records will be provided. | | | | | |
| Office Labs Operative Diagnostic Physical Notes Notes Reports Therapy | Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies. At no time will the cost-based fees exceed NC law (Statute: §44-115-80) | | | | | |
| Specify Date(s) of Service: | I understand I will be responsible for the charges incurred in the release of my | | | | | |
| Body Part: | protected health information. | | | | | |
| Other (please specify): | Rates are determined by Delivery Method Selected. *** PAYMENT OPTIONS: Check, Credit Card or Money Order | | | | | |
| | DELIVERY [] Send by [] Mail Records [] Mail Records METHOD Email* on CD on Paper | | | | | |
| Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at (800) 560-3800 | *A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided | | | | | |
| Authorization to Release Protected Health Informat | on this form. No charge for records being released to another healthcare provider. | | | | | |
| 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: 1. I may refuse to sign this authorization and that it is strictly voluntary 2. My treatment, payment, enrollment or eligibility for benefits may no 3. I may revoke this authorization at any time in writing, but if I do, it we revocation. Unless otherwise revoked, this authorization will expire to <i>If I do not specify expiration th</i> | ot be conditioned on signing this authorization. vill not have any effect on any actions taken prior to receiving the | | | | | |
| 4. If the requestor or receiver is not a health plan or health care provid regulations and may be disclosed. | er, the released information may no longer be protected by federal privacy scribed on this form, for a reasonable copy fee, if I ask for it. I can request a | | | | | |
| 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: | | | | | |



Sharecare | HEALTH DATA SERVICES NOTICE TO PATIENTS

REQUESTING THEIR MEDICAL RECORDS

- THERE IS A PROCESSING FEE IF 10 PAGES OR MORE
 - Under 10 pages free
 - 20 page record example CD \$11.24 or Paper \$7.75
 - 40 page record example CD \$11.88 or Paper \$10.81
 - 100 page record example CD \$12.72 or Paper \$18.88
 - Actually pricing will be based on the processing time associated with the actual page count of the record
- These fees are based on an average cost model and are compliant with the Feb 2016 FAQ from the Office of Civil Rights





Instructions for Requesting Copies of Your Medical Record

California law (AB610) allows a 15-day turnaround time to process a patient's request for copies of their medical records. Our turnaround time is about 5-7 days depending on the location of your medical records (storage, outpatient department, etc.). In order to provide you with quality service we have hired an outside service, Sharecare Health Data Services, to fulfill your request.

Due to HIPAA and State regulations, we must follow strict guidelines when releasing copies of your medical records. We have provided you with a Packet and instructions to request copies of your medical records. In order to process your request, please complete and submit all of the following in this Packet:

- Consent To Release Medical Information form
- Patient Pay Program form

You may fax, mail or drop off your packet in person to:

- □ Fax # 760-631-3016
- The Neurology Center Attn. Medical Records
- 6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011
- 1955 Citracado Parkway, Suite 102, Escondido, CA 92029
- 9850 Genesee Ave, Suite 470, La Jolla, CA 92037
- 15611 Pomerado Road, Suite 505, Poway, CA 92064
- 31515 Rancho Pueblo Road, Suite 104, Temecula, CA 92592

For questions regarding the Consent form please call: (760) 631-3000

For questions about the Patient Pay form please call: (800) 560-3800 (Press #2 at the message to connect with Sharecare Customer Service)

Thank you for following these instructions and for your understanding.



Sharecare | HEALTH DATA SERVICES

Patient Requests for Medical Records

Dear Patient,

Sharecare Health Data Services (SHDS) is the Release of Information (ROI) service provider for this facility. We will process your request for copies of your medical records. We support patient access to medical records and value your privacy so we deliver your records with industry-leading accuracy and in a secure and efficient manner.

In this process, a representative from SHDS will capture electronic copies of all the information from your record according to the requirements you set in your request for copies. Your personal health information will be encrypted at all times to protect your privacy. We will then deliver these copies to you in the form and format requested wherever possible. The most common delivery methods are printed copies or copies burned to a CD.

There are fees associated with the ROI process that are governed by state and federal guidelines and SHDS adheres to these guidelines. The fees charged are shown below.

| Cost Category | Cost for Delivery on CD | Cost for Delivery on Paper | |
|-----------------------------------|-------------------------------------|--|--|
| | Varies based on storage type of | Varies based on storage type of | |
| | original records (paper, electronic | original records (paper, electronic or | |
| Labor* | or multi-system) | multi-system) | |
| Materials | \$0.98 | \$0.05/pg. | |
| Postage | \$2.66 | \$1.63 | |
| Example: Multi-system storage | | | |
| 20-page record, mailed to patient | \$11.17 [¥] | \$8.77 | |

Records 10 pages and under are sent at no charge

*Labor is based on categories allowed under OCR Guidance

[¥]Overall cost is less for paper until record exceeds approximately 50 pages due to material and postage costs.

SHDS is dedicated to assist you with access to your medical records and want to do all we can to meet your needs. If you have questions about our services or your bill, please call us at 1-800-560-3800.

Thank you, Sharecare Health Data Services



Sharecare | Health Data Services

| USE THIS AREA FOR PAYMENT OPTIONS, PAY ONLINE, CREDIT CARDS, CHECKS, ETC. | | | | | | |
|---|----------|------------------|-------|-----|--|--|
| VISA MasterCard | AMERICAN | | | | | |
| Patient Name: | | Daytime Ph #: | | | | |
| Credit Card #: | | Expiration Date: | | | | |
| Name on Card: _ | | Signature: | | | | |
| Billing Address: | | | | | | |
| | Street | City | State | Zip | | |