OA Centers for Orthopaedics
Spectrum Healthcare Partners

The Health Information Management (HIM) department is committed to maintaining your medical records and keeping your information private and secure in accordance with federal and state regulations and patient rights. For additional information regarding health records and privacy, please view our Notice of Privacy Practices.

HOW TO OBTAIN A COPY OF YOUR MEDICAL RECORDS?

While you have the right to access your information, the medical chart is the property of OA Centers for Orthopaedics (OA). If you were referred to OA by another provider, and shared that information with us, a copy of the initial office visit report will automatically be forwarded to him/her.

If you desire a copy of office visit documentation or images to be sent to yourself or another entity, you must complete an **Authorization to Release Protected Health Information** form. A completed form is required for ALL such requests. You may complete a form online at www.orthoassociates.com. Select **For Patients**, scroll to **Request Records**, and follow the prompts.

To request a form be faxed or mailed to you, please call (207) 828.2209.

Please forward the completed, signed, and dated form to:

OA Centers for Orthopaedics
HIM Department
33 Sewall Street
Portland, Maine 04102

OR

Fax the completed form to:

207-553-7168.

HOW LONG WILL IT TAKE FOR MY REQUEST TO BE PROCESSED?

Processing times may vary depending on the complexity of the request; however, in most cases requests are completed within five to seven business days from the date of receipt.

ARE REQUESTS PROCESSED AT OA?

No. We partner with Sharecare Health Data Services.

IS THERE A CHARGE ASSOCIATED WITH YOUR REQUEST FOR COPIES OF RECORDS?

In accordance with State of Maine Statutes, there may be a "reasonable cost-based fee" If it is deemed that any processing fees apply, we will contact you before completing your request.

If you have an upcoming appointment with another physician/medical provider, someone from his/her office may contact us directly by sending a faxed request to (207) 553-7168, as laws allow us to release records to them without the need for you to complete a form.

**** Please be advised that we are unable to accommodate "walk-in" requests.****

This authorization is to release and disclose Protected Health Information (PHI) pertaining to:

PATIENT INFORMATION

PLEASE PRINT

Must be fully completed

Name:

Date of Birth: Phone:

Address:

City: State: Zip:

Email:

WHO do you want to receive your information?

I hereby authorize OA Centers for Orthopaedics to release medical records to:

OA Centers for Orthopaedics
Spectrum Healthcare Partners

Name:

Address:

City: State: Zip:

Telephone: Fax:

Email:

WHAT information do you want released? What specific records/report(s) do you want released? Check appropriate boxes:

- Indicate date(s) of service and/or body part(s) From:_____To:_____/Body Part(s)_____
- *(If no date range is entered we will release records for the last year of treatment with our providers.)*

☐ Physician office visit notes ☐ Operative Reports ☐ Radiology Reports ☐ *Radiology Images on CD* **

☐ Other (specify):

*** The fee for patient copies of x-rays and/or MRIs on a CD is $5.00****

HOW do you want your information delivered?

☐ Fax as above ☐ Email as above ☐ Mail as above

PURPOSE of release... why is it needed?

☐ Continuing care ☐ Transfer of care ☐ Personal use/Review

☐ Other (specify):

Fees may be charged in accordance with State and Federal Statutes

Authorization to Release Protected Information

I **DO** authorize disclosure of any information relating to **Alcohol and/or Drug Abuse Treatment** ☐ I **Do Not**

I **DO** authorize disclosure of any information relating to **treatment by a Mental Health Professional or Program** ☐ I **Do Not**

I **DO** authorize disclosure of any information which refers to **HIV Test Results, Status, or Treatment** ☐ I **Do Not**

Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences, if it is misused, such as negative treatment in your personal life, at work, or by insurance companies. It can be important in providing you needed services and healthcare.

I Understand That:

* I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences.

* I can revoke all or a part of this authorization at any time during this time period by providing written notice to the Health Information Management Department , **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for the denial of health benefits, of other insurance coverage or benefits.

* I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.

* I understand that I am entitled to a copy of this authorization, upon request.

This authorization becomes effective immediately and shall expire on _____. If no date is given, this authorization will remain effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

Signature of Patient or Authorized Representative **Date / Time** **Printed Name**

If signed by other than patient, indicate legal relationship: