

Dear Patient:

Thank you for contacting **Medical Specialists of the Palm Beaches** Medical Records
Department. To better serve you with your request for medical records, **Medical Specialists of the Palm Beaches** 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.
 (PLEASE SELECT ONLY ONE OPTION)
- 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 and must include a copy of your Driver's License.
- You may Mail, Email or Fax the completed Authorization form to:
 - Mail: Medical Specialists of the Palm Beaches, Inc. 1732 South Congress Ave, #341 Palm Springs, FL 33461
 - **Email:** mspbmedicalrecords@msbhealth.com
 - **Fax:** 561-649-7028
 - You can give the authorization form to your doctor office and ask them to submit it interdepartmental or fax if the patient is unable to do the above

For Records being sent to Another Health Care Provider

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:

877-570-4335

Thank you,

Medical Specialists of the Palm Beaches, Inc.



4.

Patient Authorization

sign if they are not over this age limit.





Authorization to Disclose Protected Health Information

The undersigned authorizes:

Medical Specialists of the Palm Beaches

to release my health information as noted below:

| | | | | Other Names? | | |
|--|--|--|--|---|---|--|
| | | | Date of Birth: Phone #: | | | |
| • | | Zīþ | Filone #. | | _ | |
| Release Information | ı To | | | | | |
| Email address for reco | ord delivery: Please | ensure email address | is legible! | | | |
| PDF file on Sharecare HDS | Mail Express portal. If | you do not retrieve your red | your own or that of your designated ords within 30 days, they will be deecting your records. If so, an invoice | leted. You will receive an er | mail from hds.sharecare.com | |
| Name/Facility: | | | Attention: | | | |
| Address: | | | Phone: | | | |
| City: | State: | Zip: | Fax #: | | | |
| Information to be R | eleased | | If you fail to spec | cify, a 1 year abstrac | t will be provided. | |
| | 1 year abstract of mos, procedures & tes | ny records (includes mo | ost (Pig | ease pick <u>ONE</u> delivery | option) | |
| | 2 year abstract of r edures & testing, up | my records (includes of to 2 years) | fice ☐ Send by email ☐ Records on CD | ☐ Fax to Doctor | ☐ Records on Paper | |
| Date Range: Progress Notes Operative Repoi | ☐ Radiology Rep | oorts | reasonable cost-based | ord, the rate will increase p | ling the copies. If you want roportionally based on the | |
| Radiology Disc | | | cost. At no time will the | e cost-based fees exceed | State law. | |
| Authorization to Rel | ease Protected Hea | lth Information | | | | |
| I acknowledge and he results, or AIDS inform | | | rmation may contain alcohol, o | drug abuse, psychiatric | , HIV testing, HIV | |
| benefits may not be contained to the con | onditioned on signing actions taken prior or condition: on plan or health care I understand that I | ng this buthorization. I receiving the revoc to receiving the revoc If I do not spec e provider, the released may see and obtain a | it is strictly voluntary. My trea may revoke this authorization a ation. Unless otherwise revok ify expiration this autorization I information may no longer be copy of the information describes | at any time in writing, b red, this authorization w will expire in 90 days. e protected by Federal | ut if I do, it will not vill expire on the If the requestor or Privacy Regulations | |
| Please confi | rm you have fille | m after I sign and date d out this form in it ble to fulfill this rec | s entirety - if form is inco | mplete, or if protect | ed information is | |
| Signature: | | | Date: | | | |
| , | | e of, a parent or nust be supplied with a c | guardian must sign release formopy of this form. | m. If patient is undable to | sign, a copy of the legal | |
| Patient Information address, and DOB. | : Ensure the patient | fills out this entire por | tion with full name (along with | any nicknames or pre | vious names used), | |
| | Information To: We need the full name and address of where the patient is wanting records sent and would need a fax number to electronically send records to another doctor. | | | | | |
| | tion to be Released: The patient needs to make a selection as to what they are wanting released. If they do not make a selection, to sending a 1-year abstract of records. | | | | | |
| Delivery Option: Th | nis option allows us to know exactly how the patient is wanting the records delivered, via: email, fax or paper copies. | | | | | |
| | rization to Release Protected Health Information: Only applicable to any sensitive information that may be in the chart. If this is not ed, we will not include any of this info in the record set that is sent. | | | | | |
| | | | | | | |

note—The legal age for a child to sign a request is in the state of . We would typically have to have a parent or guardian



Authorization to Disclose Protected Health Information

The undersigned authorizes: MEDICAL SPECIALISTS OF THE PALM BEACHES mspbmedicalrecords@mspbhealth.com

(P) (561) 649-7000 ext. 4211 (F) (561) 649-7028 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! | | | | | | | |
| | | | | | | | |
| 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 Trea | atmentLegalInsuranceTransferOther: | | | | | | |
| 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 pick ONE delivery option) | | | | | | | |
| Please release a 2-year abstract of my re notes, labs, procedures & testing, up to 2 y | years) [] Records on CD | | | | | | |
| Date Range: Progress Notes □ Radiology Reports □ Late □ Operative Reports □ Injections □ Physic □ Other: | 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 | | | | | | |
| Radiology Disc 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, | | | | | | | |
| enrollment or eligibility for benefits may not be at any time in writing, but if I do, it will not have otherwise revoked, this authorization will expression this authorization will expression, the released information may no longer | outhorization and that it is strictly voluntary. My treatment, payment, be conditioned on signing this authorization. I may revoke this authorization we any effect on any actions taken prior to receiving the revocation. Unless pire on the following date, event or condition: If I do not to days. If the requestor or receiver is not a health plan or health care niger be protected by Federal Privacy Regulations and may be disclosed. I of the information described on this form, for a reasonable copy fee, if I ask | | | | | | |
| 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: | | | | | | |

^{*} 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.