UCBC
UNIVERSITY CANCER
& BLOOD CENTER

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3320 Old Jefferson Road | Bldg. 700 Athens, GA 30607 | P: 706.353.2990 F: 706.353.2992 | www.universitycancer.com

Dear Patient:

Thank you for contacting University Cancer & Blood Center Medical Records Department. To better serve you with your request for medical records, **UCBC** 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.*

You may return the completed Authorization form via mail, fax or in person.

To fax your request, please fax to: (706) 353-4357.
Please include a copy of your Driver's License along with the completed Authorization.

If you choose to submit your request in person or mail in your request, please use the address below:
University Cancer & Blood Center
Attention: Medical Records
3320 Old Jefferson Road, Building 700
Athens, GA. 30607

*****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: **(866) 967-0133**

Thank you,

Medical Records Supervisor
University Cancer & Blood Center

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The undersigned authorizes University Cancer & Blood Center to release my health information as noted below.

***Phone 706-353-2990** | **Fax** 706-353-4357*

sharecare
HEALTH DATA SERVICES

PART A: PATIENT INFORMATION

Patient Name:	D.O.B.	SSN: XXX-XX-_____
Address:	City/State/Zip:	
Phone: (_____) _____- _____	**FOR OFFICE USE ONLY** - UCBC MRN:	

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

☐ Self ☐ Personal Representative **Provide name and contact # below** ☐ Other 3rd Party (Please provide information Below)

Representative/3rd Party:	Phone:	Fax:
Address:	City/State/Zip:	

PART C: INFORMATION TO BE RELEASED (check all that apply)

Records Requested		**Treatment Date(s):**
❑ Abstract Chart Copy Includes: Office Notes. Diagnostic Reports, Hospital Consultations, Chemotherapy Flowsheets for the last 12 months	❑ Radiology Report ❑ Radiology Images ❑ Consultation Report ❑ Chemotherapy Flowsheet ❑ Laboratory/Pathology Reports ❑ Itemized Billing	Date(s) of service requested **(PLEASE BE AS SPECIFIC AS POSSIBLE)**

PART D: PURPOSE OF REQUEST

❍ PERSONAL	❍ CONTINUED CARE	❍ LEGAL	❍ INSURANCE	❍ DISABILITY/FMLA

PART E: FORMAT AND DELIVERY OF INFORMATION

FORMAT (PLEASE ONLY CHOOSE ONE)		DELIVERY METHOD	
❍ PAPER		❍ P/U @ UCBC	❍ MAIL
❍ FAX (TO HEALTHCARE FACILITY ONLY)		FAX : (_____) _____-_____	Attn:
❍ CD	❍ USB FLASH DRIVE	❍ P/U @ UCBC	❍ MAIL
❍ SECURE E-MAIL	EMAIL ADDRESS:		

PART F: REVIEW AND APPROVAL

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Mental and Behavioral Health	☐ Substance Use Disorder	☐ Genetic Testing

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, UCBC will continue to provide treatment and seek payment for services provided. UCBC may charge a fee for providing the information specified above.

This Authorization will expire one year from the date below unless revoked or another otherwise specified here: _____

Signature	Printed Name	Date
Representative Signature	Printed Name	Date

PART G: REPRESENTATIVE (complete if signed by personal or authorized representative)

Relationship to Patient:	Phone Number:	Documentation Received? ☐ YES ☐ NO

If you are not the patient you MUST attach documentation of your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)

SEND COMPLETED FORM TO: mmoon@universitycancer.com Fax: 706.353.4357 OR
University Cancer & Blood Center 3320 Old Jefferson Road Bldg. 700 Athens, GA. 30607;
For Questions Call: 706.353.2990