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 Photo ID 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: **877-391-9890**

Thank you,

Medical Records Supervisor
University Cancer & Blood Center

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Authorization to Disclose Protected Health Information
The undersigned authorizes **University Cancer & Blood Center**
3320 Old Jefferson Rd. Bldg. 700 Athens, GA. 30607
Fax: (706) 353-2992
to release my health information as noted below:
******All sections must be completed 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 address is legible!*

You must provide a valid email address and name of your designated recipient if electronic 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 COMPLETED) *If you fail to specify, 1 year of records will be provided.*

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Hospital Consults

Specify Date(s) of Service: _____

☐ **Other** (please specify):

_____

Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at 877-391-9890

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 GA law O.C.G.A §31-33-3

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Check, Credit Card or Money Order***

DELIVERY METHOD	[ ] Send by Email*	[ ] Mail Records on CD	[ ] Mail Records on Paper

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 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 not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving to revocation.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
If I do not specify expiration this authorization will expire in 90 days.

4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its
if form is incomplete, we will be unable to fulfill this request.

Signature*:_____ **Date:** _____

*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)