

Dear Patient:

Thank you for contacting **FOUNDCARE** Medical Records Department. To better serve you with your request for medical records, **FOUNDCARE** 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. Please mail/fax/drop-off the completed Authorization form to FOUNDCARE*

If you choose to fax your request, please include a copy of your photo ID and fax to:

Palm Springs: (561) 283-0224 North Palm Beach: (561) 776-0727 Pediatric North: (561) 848-9059

If you choose to mail request, please send to:

FOUNDCARE

Attention: Medical Records 2330 South Congress Avenue West Palm Beach, FL 33406

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:

954-399-3807

Thank you,

Medical Records Supervisor

FOUNDCARE





Authorization to Disclose Protected Health Information
The undersigned authorizes:
FoundCare, Inc.
2330 South Congress Avenue, West Palm Beach, FL 33406
(P) (561) 432-5849
Palm Springs (F) (561) 283-0224

Palm Spring Beach, PL 33406 (P) (561) 432-5849 Palm Springs (F) (561) 283-0224 North Palm Beach (F) (561) 776-0727 Pediatric North (F) (561) 848-9059 to release my health information as noted below:

Patient Information								
Patient Full Name:		Other Names?						
Patient Address:		Date of Birth:						
City:	State	: Zip:		Phon	e #:			
Release Information To								
Email address for recor	d delivery: Please	ensure email add	ress is le	gible!				
If email delivery is preferred, you PDF file. If you do not retrieve you be a fee for collecting your record	ur records within 30 days,	they will be deleted.	You will re	ceive an email containi	•		•	
Name/Facility:				Attention:				
Address: Phone:								
City:								
Purpose of Request:	Personal [reatment	Legal	Insurance _	Transfer	Other:		
Information to be Rel				you fail to specify				
Please release a 1-y most recent notes,		•			e pick ONE		•	
Please release a 2-year abstract of my records (office notes, labs, procedures & testing, up to 2 years)			_	Send by Email Records on CD		Ooctor	[] Records on Paper	
Date Range:: □ Progress Notes □ Radiology Reports □ Labs □ Operative Reports □ Injections □ Physical Therapy □ Other:				Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to 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 cost-based fees exceed Florida Statute: (395.3025(1))				
Authorization to Rele	ase Protected He	alth Informat	ion					
I acknowledge and he	=				-		ol, drug abuse,	
psychiatric, HIV testir				`	Please Initia			
I understand that: I may eligibility for benefits may if I do, it will not have any will expire on the following days. If the requestor or refederal Privacy Regulation form for a reasonable con	enot be conditioned of effect on any actions of date, event or con eceiver is not a health ons and may be disclosed by fee, if I ask for it. I	on signing this austaken prior to readition: plan or health cosed. I understand can request a co	eceiving care prov that I m py of this	on. I may revoke the revocation. U _ If I do not specify ider, the released ay see and obtain s form after I sign a	this authorizathis otherwing expiration this information material a copy of the and date it.	tion at any se revoked authorization nay no long information	y time in writing, but d, this authorization fon will expire in 90 ger be protected by on described on this	
STOP Please co	onfirm that you hav information is r			•			or if protected	
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.