Ventura Orthopedics

sharecare | HEALTH DATA SERVICES
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Process and Fee Explanation Letter
Ventura Orthopedics

Dear Patient:

As a patient, you have a right to copies of your medical information. In addition, medical records are legal documents that must be maintained by Ventura Orthopedics. Under federal and state law, Ventura Orthopedics or its medical records Release of Information provider, Sharecare Health Data Services, is allowed to recover certain costs related to making copies of your medical records available to you. The fee we charge is cost-based to include only the labor, materials and postage as allowed by HIPAA and highlighted by the Omnibus Final Rule. The requested output method will impact the cost to you. For all records greater than 10 pages, a CD containing records will cost less than printed records, so please indicate your preference. As an example, including labor, materials and postage, a 40-page record would cost $8.67 on CD and $11.59 on paper.

Please fill out the attached authorization form completely and submit via fax or mail.

Request by Fax: (805) 527-5246

Request by Mail: Addresses of Ventura Orthopedics' clinics are available on website.

An invoice will be sent within 5-7 days of receipt to the address on your request. Invoicing information may be reviewed sooner by calling customer service below. This fee can be remitted by check or credit card.

Pay by Phone: (800) 560-3800 Press #2 for Customer Service – Leave message for call back if no live contact.

Pay by Mail: Sharecare Health Data Services
8344 Clairemont Mesa Blvd. Suite 201
San Diego, CA 92111

Pay Online: http://hds.sharecare.com
Click on Record Access > Pay Online
https://payment.hds.sharecare.com/payments
Enter your email address for Receipt – Invoice # - Amount of Invoice

Your request will be fulfilled upon payment. For questions, please contact Sharecare Health Data Services at **(800) 560-3800 #2** for Customer Service or Ventura Orthopedics Medical Records Department at **(800) 698-1280**.

Thank you for your confidence,

Ventura Orthopedics

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Outgoing Records
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: _____

Date of Birth: _____ SSN: _____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.
I understand that I have a right to receive a copy of this Authorization.

Requesting records from:

Ventura Orthopedics
Phone: (800) 698-1280
Fax: (805) 527-5246

Where to send the records to:
Name/Facility: _____
Attention: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____
☐ Check box if you prefer a CD

Please send records from the following date range: From: _____ To: _____

☐ Labs ☐ History and Physical ☐ Consultation Notes
☐ Progress Notes ☐ X-rays/Film ☐ Billing Records
☐ Other

Purpose of requested use: ☐ Continuing Care ☐ Patient Request
☐ Insurance ☐ Legal ☐ Other

I authorize release of the following information:

☐ Mental health treatment information Initial if requesting: _____
☐HIV test results Initial if requesting: _____
☐ Alcohol/drug treatment information Initial if requesting: _____

**If not checked and initialed, the records containing such information can NOT be released.*

Duration: Date authorization expires: _____
**If no date is given, this authorization will expire 6 months from the signature date.*

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Ventura Orthopedics. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Redisclosure: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: _____ Date: _____

Representative Signature: _____ Relationship to Patient: _____