



Re: Jeffrey Cusmariu, M.D.

Dear Patient,

This is to inform you that Dr. Jeffrey Cusmariu is leaving OrthoSports Associates and relocating his medical practice to St. Vincent's Orthopedics. Effective March 1, 2017, Dr. Cusmariu's new office address will be:

St. Vincent's Orthopedics
2700 10th Avenue South
Birmingham, Alabama 35205
Telephone: 205-933-7838

All of your patient records will continue to be maintained by OrthoSports Associates. If you would like to have your patient records transferred to Dr. Cusmariu and St. Vincent's Orthopedics please complete the attached "Medical Records Release Form" and return it by email, facsimile or mail to:

Acton Corporation
13521 Old Highway 280
Suite 141
Birmingham, Al 35242
Fax: (205) 408-3664
Email: requests@actoncorporation.com

The following OrthoSports physicians remain available to care for you on the campus of St. Vincent's Birmingham and in Gardendale:

David Shane Buggay, M.D.
Francisco Caycedo, M.D.
St. Vincent's Birmingham
833 St. Vincent's Drive
Building 3, Suite 403
Birmingham, Alabama 35205
Telephone: 205-939-0447

Ryan T. Cordry, M.D.
Ken Jaffe, M.D.
Gardendale Medical Center
2217 Decatur Highway
Gardendale, Alabama 35071
Telephone: 205-418-1260

If you have any questions or concerns, please contact Bethany Sweatt at (205) 939-0447.

Sincerely,

The Physicians and Staff at OrthoSports Associates

MEDICAL RECORDS RELEASE FORM

Please Print:

Patient Name: _____ Patient Address: _____
Date of Birth: _____

I, the undersigned, authorize and request that OrthoSports Associates, LLC release a copy of the Patient's entire medical record to the following Recipient for the purpose of the Patient's continued treatment:

Recipient: St. Vincent's Orthopedics
2700 10th Avenue South
Birmingham, Alabama 35205

I understand that the health information to be released may include inpatient admission records, ER visit records, outpatient clinic notes, diagnostic testing reports, films, consults, doctor's orders, progress notes, nurse's notes, laboratory testing results, reports, correspondence, consultations, memoranda, treatment plans, discharge summaries, medical summaries, examination records, history and physicals, diagnoses, consents and/or any writing of any kind pertaining to my physical and mental condition and treatment. I understand the information to be released may also include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health (not including psychotherapy notes) and alcohol and substance abuse treatment. I hereby authorize the release of this type of information.

I understand that I have the right to revoke this Release at any time by sending written notification to OrthoSports Associates, LLC. I understand that a revocation will have no effect on the disclosure of information made under this Release prior to the receipt of my revocation.

I understand that my treatment, payment, or eligibility for benefits at and by OrthoSports Associates, LLC will not be conditioned on me signing this Release. I understand that this Release is voluntary.

I acknowledge that information disclosed pursuant to this Release may be subject to redisclosure by the Recipient and may no longer be protected by state or federal law.

I understand that I have the right to receive a copy of this Release upon request. I agree that a photocopy or facsimile copy of this Release shall be valid and effective, just as the original.

This Release shall remain in full force and effect until six (6) months from the date signed, at which time this Release shall automatically expire.

Signature of Patient or Legally Authorized Representative for the Patient Date

Printed Name of Legally Authorized Representative
(if applicable)

Description of Legally Authorized Representative's Authority
to Sign for the Patient (e.g., parent, legal guardian, etc.)
(if applicable)