Authorization to Disclose Protected Health Information

The undersigned authorizes:

The Orthopedic Clinic

to release my health information as noted below:

Patient Information

Patient Full Name: _____ Email: _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Facility: _____ **Attention:** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ___ Personal ___ Treatment ___Legal ___Insurance ___ Transfer ___Other:

Information to be Released

If you fail to specify, a 1-year abstract will be provided.

___Please release a **1-year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2-year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**: _____:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

___**Radiology Images**; body part:_____
Date range:_____

(**Please pick ONE delivery option**)

[ ] Send by Email	[ ] Send by Mail [ ] Paper [ ] Disc	[ ] Fax

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 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: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. 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 the 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.* 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. 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 entirety—if form is incomplete, or if protected information is not released; we may be unable to fulfill this request.

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.*