Authorization For Disclosure of Medical Record Information

Orthopedic Center of Florida
Ph: (239) 482-2663 Fx: (239) 482 7585

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby authorize **Orthopedic Center of Florida** to release my medical record information to:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: **Transfer/Reason**_____ Other _____

Information to be Released

Please provide a 2year abstract of my records -

Please provide a 3 year abstract of my medical records -

Other - please be specific, include dates under comments-

PLEASE BE ADVISED THERE IS A CHARGE FOR THE RECORDS REQUESTED.

Florida Statute Copy Fee: $1.00 per page for the first 25 pages. $.25 for any pages over 25 plus postage.

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial each line below to confirm your choices

I ☐ **DO** ☐ **DO NOT** want ***Psychiatric Treatment Notes** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

I ☐ **DO** ☐ **DO NOT** want information about _____ released _____

Other sensitive information?

STOP

Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected infomation is not released, we may be unable to fulfill this request.

Sign **Date**

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Witness **Date**

Know Your Privacy Rights
Refer to the HIPAA
"PRIVACY NOTICE"

*This Authorization is valid for **ONE year** (365 days for alcohol/drug abuse treatment) unless you specify other wise:_____. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that APMSS has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to

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