PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____

Address: ____

City: ______________________ State: _________ Zip: _________________

I hereby consent to the release and disclosure of my personal health information to:

Name (Individual or Organization): ____________________________________

Address: ____

City: ______________________ State: _________ Zip: _________________

For the following purpose(s):

____ Continuing Medical Care ____ Personal Use
____ Information for Insurance Co. ____ Information for Attorney
____ Other (please specify)___________________________________

This authorization for release includes my personal health information consisting of:

____ Initial Evaluation ____ Operative Reports ____ Medical Status
____ Progress/Office Notes ____ Discharge Summary ____ Work Status
____ X-ray Only ____ X-Ray Report Only ____ Both X-ray films and Report
____ Other (please specify)____

_____ Mail to above _____ Call when records are ready Phone #: __________________

I understand that the information outlined in this release will be disclosed according to the instructions of this release within five (5) business days of Florida Orthopaedic Institute's having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Patient Signature: ____Date: _____________

DOB: ___________________________ SS#: ____________________________________

FOR OFFICE USE ONLY:

MR#______________________

Document flow: Patient's Medical Record.

☐ **REVOCATION:**
This authorization was revoked on______________(date).
Revocation letter/document must be attached.

Revised: 4/18/03