FLORIDA ORTHOPAEDIC INSTITUTE

MR#: ___________

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please print clearly all information and sign where indicated below

Patient Name: ______________________________
DOB: ____________________ Social Security Number (last 4 digits only): ______
Address: ______________________________
City: ____________________ State: ________ Zip: ____________

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

(Please print the complete address. Any missing information may cause a delay in obtaining the records.)

Name (Individual or Organization): ______________________________
Address: ______________________________
City: ____________________ State: ________ Zip: ____________

For the following purpose(s): __Continuing Medical Care __Personal Use_
__Information for Attorney __Information for Insurance Co.

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

__Initial Evaluation __Medical Status __Progress Office Notes
__Discharge Summary __Work Status
__X-ray film/CD Only __X-Ray Report Only __Both X-ray CD/Film and Report
__MRI/CT CD Only __MRI/CT Report Only __MRI/CT CD and report
__Other (please be specific-i.e. body part, physician and dates of service): ____________________

____

******Operative Reports must be obtained through the Hospital or Ambulatory Surgery Center where the procedure/surgery took place******

__Mail to above address ******RECORDS CANNOT BE FAXED******
__Call when records are ready Phone #: ____________ Alternate#: ____________
__ If request to Pick-up Records: (Circle one) **TELECOM SOUTH TAMPA BRANDON SUN CITY PALM HARBOR CITRUS PARK WESLEY CHAPEL**

PICK-UP DURING NORMAL BUSINESS HOURS: M.-F. 8:00AM TO 5:00PM

__ Electronic copy via encrypted e-mail to patient ONLY Email: ____________________

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: ____________

FOR OFFICE USE ONLY:

MR#: ____________________

Document flow: Patient's Medical Record.

☐ **REVOCATION**

This authorization was revoked on __________ (date).
Revocation letter/document must be attached.

COMPLETED BY: ____________________ **DEPT:** ________ **DATE:** ____________________

Q:\HIPAA Medical Records & HealthPort Forms\HIPAAFORM05-Patient Authz to Disclose Health Infor 2016.doc Revised: 6/2016

FLORIDA ORTHOPAEDIC INSTITUTE

PATIENT RECORDS INFORMATION

In order to receive copies of your medical records and/or radiographic imaging (X-rays, MRI or CT scans uploaded to a CD) you are required to complete *a Patient Authorization to Disclose Health Information form.*

The signature on the form is valid for one year, however, each time updated records are needed a new request form is required.

MEDICAL RECORD REQUEST: (paper records only):

- From the time the signed Patient Authorization to Disclose Health Information form is received in our Patient Records Department your request will be processed within 3-5-business days.
- Please specify on your request which records are needed (i.e. dates of service, physician, body part, etc.).
- There is a charge for copying records, $1.00 per page for the first 25 pages. Every page thereafter the charge is .25 cents per page. **Federal and State laws permit a fee to be charged for the copying of patient records. Florida Orthopaedic Institute has contracted with an outside company to process requests for copying patient records. Pre-payment is not required; an invoice will be mailed to you.**

X-RAY / MRI or CT Scan REQUEST:

- From the time the signed Patient Authorization to Disclose Health Information form is received in the Xray File Room your request will be processed within 3-5-business days.
- Please specify on your request which X-rays, MRI or CT scans are needed (i.e. physician, body parts, etc.).
- All X-rays, MRI or CT scans will be uploaded to a CD. There is no charge to patients for their radiographic imaging to be uploaded to a CD.

YOUR OPTIONS ARE:

1. Mail your records and/or CD (X-rays, MRI or CT scans) directly to you.
2. You or someone other than the patient may pick up records and/or CD (X-rays, MRI or CT scans) at our main office located at 13020 North Telecom Parkway, Temple Terrace, FL 33637. If someone else is picking up your records they must have a written authorization from the patient along with their photo ID.
3. You may request your copied records and/or CD (X-ray, MRI or CT scan) to be sent by our courier service to one of our satellite offices (Brandon, Bloomingdale, Citrus Park, Northdale, Palm Harbor, South Tampa, Sun City or Wesley Chapel) for your convenience with pick-up; however, this may require a few extra days.

***** You will receive a call only if you are picking up your Medical Records and/or CD {X-rays, MRI or CT scans). A photo I.D. is required for all pick-ups. *****

PATIENT RECORDS PHONE NUMBERS:

Paper Records & Radiographic imaging requests (X-Ray, MRI or CT scan): Ext. 7136
Paper Records Request Only: Ext. 7136
Radiographic Imaging (X-rays, MRI or CT scans) Requests Only: EXT. 7223
Patient Records Department Main Phone Number: (813) 978-9700 Ext. 7060
Patient Records Department Fax Number: (813) 558-6001