FLORIDA ORTHOPAEDIC INSTITUTE®

Keeping you active.

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 Insurance Co. ____ Information for Attorney

This authorization for release includes my personal health information consisting of:
****Operative Reports must be obtained through the Hospital or Ambulatory Surgery Center where the procedure/surgery took place****

____ 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):_____
_____

_____ **Mail to above** *****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: MONDAY THROUGH FRIDAY 8:00AM TO 5:00PM.

_____ **Electronic copy via encrypted e-mail to patient ONLY ****
_____ **Email address is required:** _____

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:**

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 X-ray 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 and/or Radiographic imaging (X-ray, MRI or CT scan) requests Ext. 7136
Patient Records Department Main Phone Number (for other inquires): (813) 978-9700 Ext. 7060
Patient Records Department Fax Number: (813) 558-6001