



PATIENT AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Email Address: _____
(please print clearly)

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

***FROM:** FLORIDA ORTHOPAEDIC INSTITUTE

***TO:**

RECIPIENT Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Fax: _____ Email: _____ (please print clearly)

***Please indicate delivery method:**

 Mail E-mail Fax (no personal fax numbers are permitted)

***Please select and specify below records to be released:**

- All records
- Office Notes - date range: _____
- Therapy Notes - date range: _____
- Radiology Reports - date range: _____
- Images via E-Mail
- Images on CD * NOTE: CDs are for delivery by MAIL ONLY
- Operative/Procedure Reports - date range: _____
- Lab/Testing Results - date range: _____
- Other (Please specify): _____

Please indicate any sensitive information **you DO NOT** wish released such as genetic or hereditary testing results, substance abuse information, HIV testing, STD testing, or mental/behavioral health records:

I understand that the information outlined in this release will be disclosed according to the instructions of this release within seven (7) 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).

***Patient/Authorized Signature:** _____ **Date:** _____

**Form can be sent to Sharecare via fax (813) 558-6001 or email sharecare@floridaortho.com.
For any questions, please call Sharecare at (813) 280-4345. Thank you!**