HEALTHMARK GROUP

FOI FLORIDA ORTHOPAEDIC INSTITUTE®

I AUTHORIZE FLORIDA ORTHOPAEDIC INSTITUTE TO RELEASE MEDICAL RECORDS INFORMATION

1

PROVIDE THE PATIENT'S INFORMATION **MUST BE COMPLETED**

Name: Date of Birth: Email:

2

HOW WILL FLORIDA ORTHOPAEDIC INSTITUTE RELEASE THE INFORMATION **SELECT ONE OPTION**

☐ **By Secure Email to Download Records (1 – 3 day delivery)** ☐ **By Fax** ☐ By Mail* (7 – 14 day, dependent on USPS/FedEx)

*Records exceeding 60 pages will be charged a shipping fee of $15.00 and over 500 pages will be charged a fee of $25.00.

3

WHO/WHERE FLORIDA ORTHOPAEDIC INSTITUTE WILL RELEASE THE INFORMATION TO **MUST BE COMPLETED**

Name of the facility/person receiving the records:_____

Email: Fax Number:

Address:

City: State: Zip Code:

4

RECORDS TO BE RELEASE **MUST CHOOSE ONE

Dates of Service - Please provide a copy of records **from** _____ **through** _____

Dates of Service – ☐ **Last 2 years**

5

Medical, Billing, and Radiology are 3 separate departments. Please indicate "Yes" or "No" in each section. If you choose "Yes", please indicate which items you need in each section.

Medical Records ☐ Yes ☐ No

☐ All Medical Records ☐ Radiology Reports(Does not include Imaging CD)

☐ Office Visit/Clinic Notes ☐ Labs/Testing Results (EMG/NCS, etc)

☐ Therapy Notes ☐ Other _____

****OPERATIVE REPORTS or OTHER SURGICAL RECORDS MUST BE REQUESTED FROM THE FACILITY WHERE THE SURGERY TOOK PLACE.**

Billing Records ☐ Yes ☐ No

☐ Billing Statement

Radiology Imaging ☐ Yes ☐ No

Includes MRI, Xray, etc.

☐ Imaging CD USPS/FedEx 7-14 Days

☐ Imaging Electronic Delivery* 1-3 Days

*Efferent/Secure Email

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Purpose for Disclosure

☐ Continuing Care ☐ Transfer of Care ☐ Referring Physician ☐ Disability

☐ Legal/Attorney ☐ Insurance ☐ Patient Request ☐ Other _____

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Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre- employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire 2 years from the date of my signature unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Reason if patient is unable to sign: _____

(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)

Florida Orthopaedic Institute outsources our release of information process to HIPAA compliant HealthMark Group.

Questions? Contact HealthMark Group at FOIstatus@healthmark-group.com