

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____ Address: _____

City/State/Zip: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Abstract/Summary |
| <input type="checkbox"/> Laboratory/pathology results | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> X-ray/radiology/CT/MRI records | <input type="checkbox"/> Other (describe specifically) _____ |
| <input type="checkbox"/> Billing records | _____ |

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

Orthopaedic Institute of Northwest Florida Phone: (850) 356-4407
PO Box 6007 Fax: (850) 807-5487
Pensacola, FL 32503

The information may be used/disclosed for each of the following purposes:

- | | |
|--|--|
| <input type="checkbox"/> At my request (only the patient can check this box) | <input type="checkbox"/> For employment purposes |
| <input type="checkbox"/> For my health care | <input type="checkbox"/> For payment/insurance |
| <input type="checkbox"/> Other: _____ | |

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or patient's personal representative)

Representative's authority to sign for patient
(i.e. parent, guardian, Power of attorney for healthcare, executor)

Printed name of patient (or representative)

Date

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to OINWFL, PO Box 6007, Pensacola, FL 32503. A copy of this signed authorization must be given to the individual.