Authorization For Disclosure of Medical Record Information

Orthopaedic Center of South Florida, 600 S. Pine Island Rd., Ste 300, Plantation, FL 33324
Ph: 954-473-6344 Fax: 954-476-9077

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby Authorize **Orthopaedic Center of South Florida** to release my medical record information to:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ○ **Transfer/Reason**_____ ○ Other _____

Information to be Released

○ Please provide records related to my Auto Accident for the following date/dates:_____

○ Please provide records related to my Workers Comp claim for the following date/dates:_____

○ Please provide records related to my Liability claim for the following date/dates:_____

○ Please provide records related to my Private Insurance claim for the following date/dates:_____

○ Please provide all records for all dates of service.

OCSF
CHART #:_____

FloridaStatute Copy Fee: $1.00 per page for first 25 pages, $.25 for any pages over 25, plus postage.

Authorization to Release Protected Information

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one

Initial each line below to confirm your choices

I ☐ DO ☐ **DO NOT** want ***Psychiatric Treatment Notes** released _____

I ☐ DO ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ DO ☐ **DO NOT** want information about ***HIV Tests & Related Information** released _____

I ☐ DO ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

I ☐ DO ☐ **DO NOT** want information about _____ released _____

Other sensitive information?

STOP

Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected infomation is not released, we may be unable to fulfill this request.

Sign Here _____ Date Here

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Witness **Date**

Know Your Privacy Rights
Refer to the HIPAA
"PRIVACY NOTICE"

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient.
The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to