

# 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 #: \_\_\_\_\_

Florida Statute 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*

- |                             |  |       |
|-----------------------------|--|-------|
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want *Psychiatric Treatment Notes released                       | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Mental Health released                   | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *HIV Tests & Related Information released | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about *Alcohol and/or Substance Abuse released  | _____ |
| <input type="checkbox"/> DO | <input type="checkbox"/> DO NOT want information about _____ released                            | _____ |



*Other sensitive information?*

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 information is not released, we may be unable to fulfill this request.

**Sign Here** →

**Signature** →

\_\_\_\_\_  
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

Rev. 12/08