ORTHOPAEDIC CENTER Of South Florida

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

Authorization For Disclosure of Medical Record Information

The undersigned authorizes **Orthopaedic Center of South Florida** to release my health information as noted below:

******All sections must be completed in order for the request to be processed******

Patient Information

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Home Number:** _____

City: _____ **State:** _____ **Zip:** _____ **Work Number:** _____

Release Information To (THIS SECTION MUST BE COMPLETED)

*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: ◯ Personal ◯ Treatment ◯ Legal ◯ Insurance ◯ Transfer ◯ Other: _____

Information to be Released (THIS SECTION MUST BE COMPLETED)

◯ 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 records for all dates of service _____

OCSF Chart Number: _____

Florida Statute Copy Fee: $1.00 per page for first 25 pages, $25 for any pages over 25.

Information to be Released (THIS SECTION MUST BE COMPLETED)

***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 *Please sign initials on ALL lines.*

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?

Please confirm that you have filled out this form in its entirety—if the form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

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

_____ **Date:** _____

Patient's Signature

_____ **Date:** _____

Parent/Legally Recognized Representative Signature

_____ **Date:** _____

Witness Signature

*** 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.*