Authorization For Disclosure of Medical Record Information

Orthopedic Specialists of Southwest Florida, 14601 Hope Center Loop, Fort Myers, FL 33912
Ph: 239-334-7000 Fax: 239-334-7070

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Full Address: _____

Home Phone: _____ Email: _____

Release Information To

I hereby Authorize **OSSWF** to release my medical record information to:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Leaving Practice/Second Opinion ☐ Personal Record Keeping ☐ Continuing Care

Information to be Released

☐ Most recent Date of Service: _____

☐ Specific Date/Dates of Service: _____

☐ All OSSWF records

☐ All records related to my Auto Accident on _____

☐ All records related to my Workers Comp on _____

☐ Other: _____

☐ Xray ☐ MRI ☐ DEXA

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