

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION



PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

NAME: _____ DOB: ____/____/____ MRN: _____

PHONE #1: (____)-____-____ PHONE #2: (____)-____-____ SOCIAL SECURITY #: ____-____-____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:

PALM BEACH ORTHOPAEDIC INSTITUTE

OTHER, NAME: _____

ADDRESS: _____

THE TYPE OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: (CHECK THE APPROPRIATE BOX(ES)):

- | | |
|---|---|
| <input type="checkbox"/> OFFICE VISIT NOTES | <input type="checkbox"/> OPERATIVE REPORTS |
| <input type="checkbox"/> HISTORY AND PHYSICAL | <input type="checkbox"/> X-RAY / MRI REPORTS |
| <input type="checkbox"/> PATHOLOGY/LAB REPORTS | <input type="checkbox"/> X-RAY FILMS |
| <input type="checkbox"/> PHYSICAL THERAPY REPORTS | <input type="checkbox"/> CONSULTATION REPORTS |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> WORK STATUS |

FROM (DATE): ____/____/____ TO (DATE): ____/____/____

PHYSICIAN'S NAME: _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION IN MY MEDICAL RECORDS WHICH MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV).

INITIALS: _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION IN MY MEDICAL RECORDS WHICH MAY INCLUDE INFORMATION RELATING TO BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE.

INITIALS: _____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

NAME: _____ Phone: (____) ____-____ Fax: (____) ____-____

ADDRESS: _____

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION



PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

NAME: _____ DOB: ____/____/____ MRN: _____

REASON FOR RELEASE:

- CONTINUATION OF CARE
- PERSONAL USE
- CONSULT/SECOND OPINION
- OTHER, BE SPECIFIC: _____
- SELECTION OF NEW PHYSICIAN
- LEGAL
- OUT OF TOWN MOVE

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE HEALTH INFORMATION MANAGEMENT DEPARTMENT. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED DUE TO RESPONSE TO THIS AUTHORIZATION OR THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT OR CONDITION:

IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN SIX (6) MONTHS.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO ENSURE TREATMENT. I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE PRIVACY OFFICER OF PALM BEACH ORTHOPAEDIC INSTITUTE.

MEDICAL RECORDS REQUESTS WILL REQUIRE A CHARGE OF \$1.00 PER PAGE FOR THE FIRST 25 PAGES, THEN \$.25 FOR EACH ADDITIONAL PAGE PURSUANT TO FLORIDA STATUTE, CHAPTER 395.

COPIES OF THE RECORD MAY BE (CHECK THE APPROPRIATE ITEM):

- PICKED UP BY: _____
- MAILED
- FAXED (ONLY TO OTHER HEALTHCARE PROVIDERS IN URGENT SITUATIONS): (_____-_____-_____)_____

SIGNATURE OF PATIENT: _____ DATE: ____/____/____

SIGNATURE OF PATIENT REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____ DATE: ____/____/____

WITNESS: _____ DATE: ____/____/____