

# Authorization For Disclosure of Medical Record Information

Orthopedic Specialists of Southwest Florida, 2531 Cleveland Ave, Ste 1, Fort Myers, FL 33901  
Ph: 239-334-7000 Fax: 239-334-7070

## **Patient Information**

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## **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     Personal Record Keeping     Part-time Resident     Continuing Care

## **Information to be Released**

- |  |  |
|--|--|
| <input type="radio"/> Most recent Date of Service<br><input type="radio"/> Specific Date/Dates of Service : _____<br><input type="radio"/> All OSSWF records | <input type="radio"/> All records related to my Auto Accident on _____<br><input type="radio"/> All records related to my WorkersComp on _____<br><input type="radio"/> Other _____<br><input type="radio"/> Xray <input type="radio"/> MRI <input type="radio"/> DEXA |
|--|--|

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*

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

**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