******STAT PLEASE******

Orthopedic Specialists of SW FL

14601 Hope Center Loop
Fort Myers, Florida 33912-4707
Office: 239-334-7000
Fax: 239-334-7070

REQUEST TO OBTAIN MEDICAL RECORDS

Patient's Name:_____ Soc Sec #(last 4 digits) _____

Date of Birth: _____ Telephone:_____

I hereby authorize and request that you release the following medical information to:

To Physician/Hospital/Facility: Orthopedic Specialists of SWFL

Phone # 239-334-7000 Fax: 239-334-7070

Address: 14601 Hope Center Loop

City: Fort Myers State: Fl Zip: 33912-4707

Information needed:

- ☐ Complete Medical Records
- ☐ Medical films
- ☐ X-Ray films
- ☐ DEXA bone scan
- ☐ Nerve conduction study
- ☐ Physical Therapy/ Occupational Therapy records
- ☐ Lab reports
- ☐ Operative report
- ☐ Prescription Information
- ☐ Biopsy report
- ☐ Other_____ _____

Note Special Dates of Interest: _____

Send by: ☐ **Courier** ☐ **Fax** ☐ **US Mail** ☐ **to be picked up**

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment. As required by state and federal law, Orthopedic Specialists of SW FL, may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on the form.

I hereby authorize_____ to release information as described above.

Patient's signature or Legal Representative _____ Date _____

Signature of parent or guardian _____ Date _____