

Florida Orthopaedic Associates, PA (FOA)
Authorization for Use or Disclosure of Protected Health Information

Full Name: _____ DOB: _____ Phone#: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR§164.508]. I wish to release medical information from my medical record from/to the following FOA office:

- ___ 1. 740 W Plymouth Avenue, DeLand FL 32720 phone 386-734-9122 fax 386-736-4348
- ___ 2. 1053 Medical Center Drive, Suite 101, Orange City, FL 32763 ph 386-774-2500 fax 386-774-2545
- ___ 3. 1337 Internationl Parkway S, Suite 1341, Lake Mary, FL 32746 ph 407-333-4507 fax 407-333-4576

Circle one: Records go to Records will be received from

Name, Address _____

Phone, Fax _____

Records (circle one) Mailed Faxed Hand-Carried

Specific documents to be released:

- | | | |
|----------------------|----------------------|-----------------------|
| ___ All Records | ___ X-Rays | ___ Discharge Summary |
| ___ Progress Notes | ___ MRI/CT | ___ Consultation |
| ___ History/Physical | ___ Operative Report | ___ Medications |
| ___ Labs | ___ Radiology Report | ___ _____ |
| ___ Physician Orders | ___ MRI/CT Report | ___ _____ |

Specific Dates of Service: _____

Purpose of information:

- | | |
|----------------------------|--|
| ___ Continued Medical Care | ___ _____ |
| ___ Insurance | ___ Patient requesting records for himself/herself |

Note to requesting party: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement.

I understand that I have the right to revoke this authorization at any time. If I decide to do so it must be done in writing. This authorization: ___ Expires: _____ OR ___ does not expire until I notify you in writing.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this Authorization.

Signature of Patient/Personal Representative Date

Printed Name Description of Personal Representative's Authority