ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.

One Orthopaedic Place • St. Augustine, FL 32086
3055 CR 210 W, Unit # 110 • St. Johns, FL 32259
Ph (904) 825-0540 • Fax (904) 825-2490
www.oastaug.com

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL INFORMATION

Release of Records

Records to be **released to** the following address:

Patient/Facility: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone: ____________________ Fax: ____________________

Reason for release of records: ____________________

*If for self, records are to be: Mailed: __________ Picked-up: __________

Request for Records

Records to be received from:

Physician/Facility: ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE

Address: ONE ORTHOPAEDIC PLACE

City: SAINT AUGUSTINE State: FLORIDA Zip Code: 32086

Phone: 904-825-0540 Fax: 904-825-2490

The following medical information should be released/received:

☐ Office Notes Date(s) of Service: ____________________

$1.00 per page for first 25 pages and $0.25 for each additional page

☐ X-ray/MRI on Disc Date(s) of Service: ____________________

☐ MRI report Date(s) of Service: ____________________

☐ Other (describe other): ____________________ Date(s) of Service: ____________________

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing. Unless otherwise revoked, this authorization will expire on the following date: ____________________. If I fail to specify an expiration date, this authorization will expire in six months.

I understand that there is a service charge for record examination and a per page charge for any copies I request. I further understand that the Medical Office has reasonable hours for record review and must be given at least a five day period notice prior to the release of my health information. I also understand that any explanations regarding medical findings must be obtained from my physician.

____

Signature of patient or Legal Representative Date

____

Patient Name Date of Birth SSN

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