ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE

Authorization to Release Medical Information

Patient Information

Patient Full Name: _____

Patient Address: _____ Date of Birth: _____ SS# _____

City: _____ State _____ Zip: _____ Phone #: _____

-Both boxes must be completed in order for your request to be processed-

Release Information From:	Release Information To:
Name/Facility: Orthopaedic Associates of St Augustine	Name/Facility: _____
Attention: Medical Records	Attention: _____
Address: One Orthopaedic Place	Address: _____
City: St Augustine State FL Zip: 32086	City: _____ State _____ Zip: _____
Phone: 904-825-0540 Fax: 904-825-2490	Phone: _____ Fax: _____

Purpose of Request:

☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability ☐ Transfer/Reason _____

☐ Other _____

Information to be Released

Unless otherwise specified, only the following information will be released:

Abstract includes most recent, up to 1 year: Medical History, Progress Notes, Diagnostic results, Reports of Consultations and Operative Reports.

☐ Please provide an abstract of my records

Please forward the records by:
Mail ☐ **or** **Fax** ☐

☐ Xray or MRI Images

☐ Entire Record

☐ Other - please be specific under comments
Comments: _____

I understand I will be responsible for the charges incurred in the release of my protected health information. Florida Statute Copy Fee: $1.00 per page for the first 25 pages, $0.25 per page thereafter. Under 10 pages: No Cost

Records being sent to another healthcare provider will be provided at no cost.

There is a $5.00 fee for Xray or MRI images on CD. Payments for CD's should be sent to Sharecare HDS 12058 San Jose Blvd. Suite 504, Jacksonville, FL 32223

Prepayment may be required prior to record being sent. Once payment is received, records will be sent by the delivery method indicated above.

Authorization to Release Protected

***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.

Check one — *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____

I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____

I ☐ **DO** ☐ **DO NOT** want information about _____ released _____

"Other sensitive information?"

STOP 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.

Patient's Signature _____ **Date:** _____

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____ **Date:** _____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 180 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosurer by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Orthopaedic Associates of St Augustine and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*