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:

Name/Facility: ______________________

Attention: ______________________

Address: ______________________

City: __________ State: ______ Zip: ______

Phone: __________ Fax: __________

Release Information To:

Name/Facility: Orthopaedic Associates of St. Augustine

Attention: Medical Records

Address: One Orthopaedic Place

City: St. Augustine State: FL Zip: 32086

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

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 ($5.00)

☐ Entire Record

☐ Other-please be specific under comments

Comments: ______________________

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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.

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?"

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 fulfil 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 the 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 redisclosure 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 is in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*

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