COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER

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Authorization to Disclose Protected Health Information

The undersigned authorizes to release my health information as noted below:

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ **Date of Birth:** _____

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

Release Information To

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax** #: _____

Email: _____ *(Patient's Only – Please ensure email address is legible!)*

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other: _____

Please forward Records by: ☐ Mail ☐ Fax (for Dr's Offices) ☐ Email (For Patients)

Information to be Released — ***If you fail to specify, a 1 year abstract will be provided.***

☐ Please release a **1 year** of my records (includes most recent notes, labs, & testing)
☐ Please release a **2 year** of my records
☐ Please release my **entire record including any imaging CD's**.
Other (please specify): _____
_____

I understand I will be responsible for the charges incurred in the release of my protected health information.
See FL Statute 64B8-10.003
Copy fee: $1.00 per page for the first 25 pages
$0.25 per page, thereafter.
Postage, if applicable
Records being sent to another healthcare provider will be provided at no cost.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ *(Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

Signature*: _____ **Date:** _____

***For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*