



**AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)**

\_\_\_\_\_ hereby authorizes the use or disclosure of the individually  
Print Patient/Legal Representative or Parent/Legal Guardian Name

**identifiable health information of** \_\_\_\_\_ **as described herein.**  
Print Patient Name Date of Birth

Person/organization authorized to <b>use/disclose</b> the information: Name/organization _____ Address _____ City, State, Zip _____ Phone: _____ Fax: _____	Person/organization authorized to <b>receive</b> the information: Name/organization _____ Address _____ City, State, Zip _____ Phone: _____ Fax: _____
---	--

**For the purpose of:**  Legal Request  Moving out of Area  New Local Physician  Other (please specify)

**Date(s) of Service: From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**This authorization will expire on the following date, event or condition:** \_\_\_\_\_  
**If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.** Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that the Orthopedic Institute of Central Florida may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

**Place your initials by each item to be released or reviewed:**

- |                         |                                    |                                    |
|-------------------------|------------------------------------|------------------------------------|
| ____ Complete Record    | ____ All diagnostic test results   | ____ Pathology/Operative Report(s) |
| Or                      | ____ Consultation/Progress Note(s) | ____ Lab only                      |
| ____ Abstract of Record | ____ Radiology only                | ____ Other (please Specify) _____  |

**In addition, place your initials by each specific item: (if applicable)**

- |                          |                       |   |
|--------------------------|-----------------------|---|
| ____ Mental Health       | ____ HIV Testing      | ____ Genetic Counseling/Testing Information |
| ____ Drug and/or Alcohol | ____ AIDS Information |   |

\_\_\_\_\_  
Patient/Legal Representative or Parent/Legal Guardian **Signature Required** Date of Authorization

\_\_\_\_\_  
Date of Birth Social Security Number (optional) Identification Shown

\_\_\_\_\_  
Translator or Interpreter's Name Telephone Number

\_\_\_\_\_  
Address City State Zip Code

**Official Use Only:** \_\_\_\_\_  
Name of Person Releasing Information Date