PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PBOI has partnered with BACTES for our medical record release needs. To receive a copy of your medical records:

1. Complete, sign, date and return this form to PBOI (Fax: 561-727-1202).
   - If the records are going to be sent to your doctor, there is no charge. The records will be faxed directly to your doctor. However, there will be a charge for CD's of digital X-Rays.
   - If the records are for your personal records, there is a charge and BACTES will send you an invoice. Upon payment, the medical records will be reproduced and transmitted or mailed by BACTES.

Patient Information		
Name (Last, First, MI)		Email
Phone	DOB	SSN
Address		

Records are to be Released *FROM*:		**Records are to be Released *TO*:**	
☐ PBOI ☐ Other (details specified below)		☐ Self ☐ PBOI ☐ Email: _____ ☐ Other (details specified below)	
Organization		Organization	
Phone	Fax	Phone	Fax
Address		Address	

Information to be Released:		**Records are to be Released from the Following Treating Physician(s):**		
☐ Office Visit Notes	☐ Work Status	☐ Baynham MD, B	☐ Green MD	☐ Norris MD
☐ Operative Reports	☐	☐ Baynham MD, C	☐ Hinson MD	☐ Sandall MD
☐ Pathology/Lab Reports	☐	☐ Burdett MD	☐ Kearse MD	☐ Schilero DPM
☐ Physical Therapy Notes	☐	☐ Cooney MD	☐ Leighton MD	☐ Seltzer DO
☐ X-Ray Films	☐	☐ Estes MD	☐ Mora MD	☐ Simovitch MD
☐ X-Ray/MRI Reports	☐	☐ Fowble MD	☐ Noble MD	☐ Wexler MD

Dates of Service for Requested Records: From _____To _____

Authorization for General Release of Information

Initials: ___ I understand that I have a right to revoke this authorization at any time. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

Initials: ___ I hereby authorize release of my medical records which may include information relating to sexually transmitted disease, AIDS, or HIV.

Initials: ___ I hereby authorize release in my medical records which may include information relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse.

Initials: ___ I understand that there is no charge for the first ten (10) pages of records.
All requests for records over ten (10) pages will require a charge of $1.00 per page for the first 25 pages, then $0.25 for each additional page pursuant to Florida Statute, Chapter 395.
All requests for digital x-rays will require a charged $5.00 per CD.

Signature of Patient/Legal Representative

Patient Signature: _____ Date: _____

Parent/Legally Recognized Representative: _____ Date: _____

Witness: _____ Date: _____

Comments or Additional Instructions