AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Completion of this document authorizes the disclosure and/or use of health information about you.
Failure to provide all information requested may invalidate this authorization.

Patient Name: Date of Birth:
Address: City, State, Zip Code:

Authorizes:
Dr.
7710 South US Hwy 1
Port St Lucie, Florida 34952
Ph: 772 335-5300 Fax: 772-200-2131

Release of Records to:

Name/Address/Fax# of Recipient:

Information to be released:
☐ All Clinic Records ☐ Allergy Records ☐ X-ray Reports ☐ Lab Reports ☐ X-ray Films
☐ Office Notes ☐ Lab Reports ☐ Photographs ☐ Other:

List other facilities records to be included when releasing for the purpose of continuing medical care:

For the following dates:

In compliance with this state's statutes which require special permission to release otherwise privileged information (**SUPER-CONFIDENTIAL)**, please release records pertaining to:
☐ Mental Health ☐ Aids Test Results ☐ Drug Abuse ☐ Developmental Disabilities
☐ Alcoholism ☐ Psychotherapy ☐ Other:

Purpose or need for disclosure: (Check applicable categories)
☐ Further Medical Care ☐ Payment of Insurance Claim ☐ Legal Investigation ☐ Application for insurance
☐ Vocational Rehabilitation Evaluation ☐ Disability Evaluation ☐ Other:
I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to medical records. In case of death, the document becomes null and void (**Must present power of attorney for records release**). _________________________ Alternate date if not one year.

I authorize the release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request. _________________________
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ ☐ Deceased
Legal Authority: ☐ Legal ☐ Legal Guardian ☐ Next of Kin Deceased

Signature of Patient:

Date: Report Date

(If signed by Person other than patient, state relationship and authorization to do so)

Authorized Signature: Relationship:

____ Initials-This authorization remains valid for two years from the date of this signature.

Restrictions:
According to federal and state regulations, if the medical information relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. This office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release doctor and employees of Coastal Orthopaedics & Sports Medicine Center of any liability that may arise as a result of any subsequent disclosure of my health information.

My Rights:
I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow to use the disclosure of. I may revoke this authorization at any time, but must do so in writing and submit it to the
Coastal Orthopaedics & Sports Medicine Center, 7710 South US Highway 1, Port St Lucie, Florida, 34952.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. If this box ☐ is checked, the requestor will receive compensation for the use of disclosure of my information.

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