WWW.OAWF.COM
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OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

430 Morton Plant St., Suite 301 • Clearwater, FL 33756 • Fax 727-461-1492
8839 Bryan Dairy Rd., Suite 240 • Largo, FL 33777 • Fax 727-397-0562
1840 Mease Dr., Suite 409 • Safety Harbor, FL 34695 • Fax 727-796-4345
2044 Trinity Oaks Blvd., Suite 110 • Trinity, FL 34655 • Fax 727-372-0235

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **OAWF** to use or disclose my individually identifiable health information as described below. I understand that the information I authorize another person or entity to receive may be re-disclosed by them, and may no longer be protected by federal privacy regulations. This authorization is for **OAWF** to:

RELEASE TO / OBTAIN FROM
(Circle one)

_____

_____

_____
City **state** **zip**

_____
Phone **fax**

NOTE: A minimum of 24 hours may be required to prepare copies of films and/or records. You may be charged a fee for duplication of films and/or records, which will be clarified with you prior to preparing the copies.

The information to be used/disclosed is specifically described below:

___ Office Notes ___ Operative Report(s) ___ MRI/CT/Radiology report(s) ___ Entire Record

___ MRI images_____ ___ Dexa/Bone Density Scan _____

___ X-ray images of _____ ___ Other _____

Purpose of Disclosure: ___ Attorney/Legal ___ Insurance/Reimbursement ___ Personal Use

___ Continued Medical Care ___ Other _____

I understand that this authorization is voluntary and that I may refuse to sign it. I understand that, if I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by notifying **OAWF** in writing. However, the revocation will not be valid to the extent that **OAWF** has taken action in reliance on this authorization or to the extent this authorization is executed as a condition for obtaining insurance coverage.

This authorization expires on/upon: _____
(valid for one year unless otherwise specified) **(Insert Applicable Date or Event)**

_____
Signature of patient/representative **date**

_____
Print Name **Relationship to patient**

Request given to Medical Records / Radiology
(circle one)

Patient Name: _____

Date of Birth: _____ **Phone:** _____

Address: _____

City, State, Zip: _____

Physician: _____ **Acct. no:**_____

****

FOR MEDICAL RECORD/RADIOLOGY USE ONLY:
Request completed: _____ by: _____ Mail/Fax/Pick-up: _____
Date initials (circle one)

Submit