OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA
A Division of Florida Orthopaedic Institute

PATIENT AUTHORIZATION TO RELEASE RECORDS

Patient Name:_____DOB:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Phone#:_____Email Address:_____
(please print clearly)

I hereby consent to the release and disclosure of my personal health information

***FROM:** ____ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA/FOI_____

***TO:**
RECIPIENT Name:_____
Address: _____
City: _____State:_____Zip:_____
Fax: _____Email:_____(please print clearly)

****Please indicate delivery method:***
____*Mail* ____*E-mail* ____*Fax (no personal fax numbers are permitted)*

****Please select and specify below records to be released:***
___ All records
___ Office Notes - date range:_____
___ Therapy Notes - date range:_____
___ Radiology Reports - date range: _____
___Images via E-Mail
___Images on CD (NOTE: CDs are for delivery via MAIL ONLY)
___ Operative/Procedure Reports - date range:_____
___ Lab/Testing Results - date range:_____
___ Other (Please specify): _____

Please indicate any sensitive information **you DO NOT** wish released such as genetic or hereditary testing results, substance abuse information, HIV testing, STD testing, or mental/behavioral health records:
_____
_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within seven (7) business days of Florida Orthopaedic Institute's having received this release authorization. ***I understand that I am free to revoke this release authorization at any time by notifying the practice in writing****. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).*

***Patient/Authorized Signature:_____Date:_____**

Form can be sent to Sharecare via fax (858) 430-4938 or email sharecare@floridaortho.com.
For any questions, please call Sharecare at (813) 280-4345. Thank you!