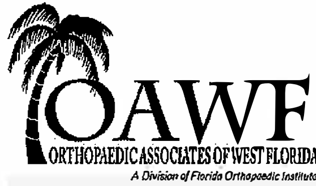

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

In order to receive copies of your medical records and/or radiographic imaging (X-rays, MRI or CT scans) you are required to complete *a Patient Authorization to Disclose Health Information form.*

FULFILLMENT OF MEDICAL RECORD REQUEST: Due to high demand for records, the date, this signed form to Disclose Health Information is received in the Patient Records Department (Clearwater office), the request will be processed within **7-business days**. Holidays and weekends are excluded.

Your paper records will be mailed or sent electronically. There is a $6.50 processing and mailing fee CD's of X-rays, MRI's or/or CT's. This must be paid prior to mailing/emailing.

Please choose ONE delivery method below:

_____ELECTRONICALLY _____MAIL

Please print all information and sign where indicated below

Patient Name: ______________________________ DOB: __________

Address: ______________________________

City: ______________________ State: ________ Zip: __________

Phone #: ____________________ **Alternate:** ____________________

Email Address: ______________________ **Fax #:** ______________

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

(Please print the complete address. Any missing information may cause a delay in obtaining the records.)

Name (Organization if other than Patient): ______________________________

Address: ____________________ **City:** ______________ **State:** _____ **Zip:** ______

Fax #: ______________

For the following purpose(s):

______Continuing Care _______Personal Use ______Info for Insurance _____Info for Attorney

This authorization for release includes my personal health information consisting of:

Please select and specify below what is to be disclosed:

____ Abstract of medical records; **Two years** of records including office notes, x-rays, CTs and MRI reports.

____ Abstract of medical records; **One year** of records including office notes x-rays, CTs and MRI reports.

____ Abstract of medical records; including office notes x-rays, CTs and MRI reports. **Date range:** __________

____ Radiology Images; **date range:** ______________________________

____ Physical Therapy records; **date range:** ______________________________

____ Other (please be specific) ______________________________

NOTE: Operative Reports must be obtained through the Hospital or Ambulatory Surgery Center where the procedure/surgery took place.

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 Orthopaedic Institue of West Florida 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).*

This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Patient Signature: ______________________________ **Date:** __________

Patient Records Request or additional information Phone Number: **(727) 461-6026, Option #5.**

Updated 8.10.2020

☐ REVOCATION DATE:

Dear Patient:

Thank you for contacting **Orthopaedic Associates of West Florida** Medical Records Department. To better serve you with your request for medical records, **Orthopaedic Associates of West Florida** has partnered with Sharecare.

Sharecare will fulfill your request for records in a safe, secure, and timely manner.

To receive a copy of your records, you will need to complete and return the attached Authorization form. Please make sure you have *specific* instructions included as to **what** records you are requesting and **where** you are requesting records to be sent. You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. For records to be delivered to another doctor, please choose fax or mail. Please select only one option. *The fax delivery option may only be used for records going to a doctor.* ***Please mail/fax/drop-off the completed Authorization form to*** **Orthopaedic Associates of West Florida.**

If you choose to fax your request, please fax to (727) 461-1492. Please include a copy of your Driver's License.

If you choose to mail request, please send to:
Orthopaedic Associates of West Florida
Attention: Medical Records
430 Morton Plant St., Suite 301
Clearwater, FL 33756

For Records being sent to Another Health Care Provider
Please provide as much contact information as possible for your other Doctor, including the address, phone & fax numbers.

You can contact a Sharecare representative at any time by calling:

813-280-4345

Thank you,

Medical Records Supervisor
Orthopaedic Associates of West Florida