Authorization to Release Medical Records to Orthopaedic Medical Group

Authorization to Release Medical Records

DATE: _____ PATIENT NAME: _____DOB:_____

TEL#: _____ADDRESS: _____

I AUTHORIZE _____ TO RELEASE MEDICAL INFORMATION TO:

ORTHOPAEDIC MEDICAL GROUP OF TAMPA BAY 13837 Circa Crossing Dr Lithia, FL 33547
Tel: (813) 684-2663 Fax: (813) 345-2983

I AUTHORIZE **ORTHOPAEDIC MEDICAL GROUP OF TAMPA BAY** TO RELEASE MY MEDICAL INFORMATION TO:

NAME OF LOCATION/Provider:	
ADDRESS:	
TEL#	FAX#:

DOCUMENTS TO BE RELEASED:

ALL RECORDS HISTORY/PHYSICAL OPERATIVE REPORTS PROGRESS NOTES

DIAGNOSTIC RESULTS XRAY FILMS AND OR COPIES DISCHARGE SUMMARY

PLEASE ENTER DATE(S) OF SERVICE: _____

PURPOSE FOR INFORMATION:

CONTINUED CARE INSURANCE PERSONAL OTHER

IF OTHER, EXPLAIN: _____

THIS REQUEST IS AUTHORIZED TO INCLUDE ANY FEDERAL AND/OR STATE PROTECTION UNDER FLORIDA STATUTES 394,459 (9) PSYCHLIATRIC INFO, 397.053/396.112 DRUG AND ALCOHOL ABUSE INFO, 381.603 HIV AND AIDS RELATED CONDITIONS AND/OR 397.50 (30 RECORDS OF MINOR PATIENT.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. IF I DECIDE TO DO SO, IT MUST BEDONE IN WRITINGAND BE PRESENTED TO THE HEALTH INFORMATION MANAGEMENT DEPARTMENT.

I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITHIT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALLY RULES.

I HEREBY RELEASE ORTHOPAEDIC MEDICAL GROUP OF TAMPA BAY AND THEIR EMPLOYEES AND AFFILLIATES FOR ANYAND ALL LIABILITY, RESPONSIBILITY, CLAIM AND DAMAGES WHICH MAY RESULT FROM THE RELEASE OF INFORMATION AUTHORIZED BY THE CONSENT FOR RELEASE OF INFORMATION.

SIGNED: _____ DATE: _____

WITNESS: _____ DATE: _____