Request for Protected Health Information

Before Florida Joint and Spine Institute, P.A. can complete your request for protected health information; we must first verify and document your identity, the information you would like to use or disclose, and the purpose in requesting this information.

If you are not the patient and are requesting protected health information you must have an authorization signed by the patient specifying the protected health information needed.

Please fill out the information below. Be as accurate and specific as possible.

Date:_____ Account #_____

Patient information:
Name:_____
Social Security #_____
Address:_____
_____**Zip**_____
Date of Birth:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____

Send records to:
Name:_____
_____
_____**Zip**_____
Phone#:_____
Fax#:_____

Signature of Person Requesting:_____

Relation to Patient (check one)
☐ Self ☐ Parent ☐ Child ☐ Attorney (or representative) of patient
☐ Legal Guardian ☐ Other;_____

I am requesting the following protected health information:

☐ Copy of Complete Chart ☐ Office Visit ☐ Radiology Reports
☐ X-Rays (film#_____) disc or films (please circle) There is a charge for films.
☐ Bone Density Exam ☐ Operative Reports
Other;_____
_____

OFFICE USE ONLY
Verifying identity using: ☐ Person Information Confirmed ☐ Driver's License
☐ Company Letterhead ☐ Other:_____
Entered in logbook on_____
Information sent to recipient via;_____on:_____
Signature of Employee:_____