☐ 6325 US 27 N, Ste 201, Sebring FL 33870 P: 863-385-2222 F: 863-382-8765
☐ 1204 Carlton Ave, Lake Wales, FL 33853 P: 863-676-9523 F: 863-676-1654
☐ 400 Ave K, SE, Bldg 4, Winter Haven, FL 33880 P: 863-299-3210 F: 863-299-2968
www.floridajointspine.com

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient Name: _____ Acct #: _____

Date of Birth: _____ Last 4 digits of Social: _____ Phone#: _____

I authorize Florida Joint & Spine Institute, PA to disclose my protected healthcare information as indicated below to: ☐ Fax ☐ Mail ☐ Patient will pick up

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

Information to be Disclosed (must be specific):

☐ Complete Chart ☐ Abstract (past year of records) ☐ Radiology reports ☐ Operative Report(s)

☐ Imaging Disc ☐ Other (must specify): _____

Purpose of Disclosure:

_____ Continued Care/Medical Treatment _____ Personal Use **(Fee Applies)** _____ Legal **(Fee Applies)**
_____ Insurance Claim **(Fee Applies)** _____ Disability/Social Security Claim **(Fee Applies)**
_____ Other (specify) **(Fee May Apply)**: _____

This Authorization shall remain in effect until revoked by me in writing. If not revoked in writing, the Authorization shall remain in effect until one (1) year from the date of my signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance thereon. I understand that if I wish to revoke this Authorization, I must do so in writing. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses**. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

Processing Time: All urgent requests for medical treatment require 2 business days prior notice! All non-urgent requests will be processed within 7 business days.

I understand that I may be charged for copies of my medical records based upon FL Statutes and pre-payment may be required.

My signature below acknowledges that I have read & understand the terms of this Authorization.

X_____ Date: _____
Signature of Patient/Authorized Representative

Relationship to Patient: _____

I have ☐ accepted ☐ declined a copy of this Authorization form. _____ (Please initial)

OFFICE USE ONLY: Verified Identity by: ☐ Driver's License/Photo ID ☐ Personal Information Confirmed
Information released to Recipient by: ☐ **Pick up** ☐ **Fax** ☐ **Mail**
Employee Signature: _____ **Date:** _____