☐ 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
☐ 70 2nd St, SE, 2nd Floor, Winter Haven, FL 33880 P: 863-299-3210 F: 863-299-2968
www.floridajointspine.com

Request for Medical Records for Continuation of Care

Patient Name: _____ Acct #: _____

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

I authorize the following provider/facility to forward a copy of my medical records to Florida Joint & Spine Institute, PA for continuation of care:

Name of Provider/Facilliity: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

Information Requested:

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

☐ Imaging Disc **(PLEASE MAIL)** ☐ Other (must specify): _____

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.

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: ☐ **Faxed** ☐ **Mailed**

Employee Signature: _____ **Date:** _____