



# AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

hereby authorizes the use or disclosure of the individually

\_\_\_\_\_

Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of \_\_\_\_\_ as described herein.

Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information:

Person/organization authorized to **receive** the information:

Name/organization Greater Orlando Orthopedic Group™ LLC  
 Address 725 Rodel Cove  
 City, State, Zip Lake Mary, FL 32746

Name/organization \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

Phone (407) 977-4130 Fax (407) 977-4139

Phone \_\_\_\_\_ Fax \_\_\_\_\_

For the purpose of:    Legal Request                      Moving Out of Area                      New Local Physician                      Other (please specify)

**This authorization will expire on the following date, event or condition:** \_\_\_\_\_

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Greater Orlando Orthopedic Group™, LLC, may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: From: \_\_\_\_\_ To: \_\_\_\_\_

Place your **INITIALS** by each item to be released or reviewed:

_____ Abstract of Record	_____ All diagnostic test results	_____ Pathology/Operative Report(s)
_____ Radiology only	_____ Consultation/Progress Note(s)	_____ Lab only
_____ Complete Record (charges may apply)		_____ Other (specify) _____

In addition, place your **INITIALS** by each specific item: (if applicable)

_____ Mental Health	_____ HIV Testing	_____ Genetic Counseling/Testing Information
_____ Drug and/or Alcohol	_____ AIDS Information	_____ STD/Communicable Diseases

\_\_\_\_\_  
 Patient/Legal Representative or Parent/Legal Guardian *Signature Required* Date of Authorization

\_\_\_\_\_  
 Patient Date of Birth Social Security Number (optional) Identification Shown

\_\_\_\_\_  
 Translator or Interpreter's Name Telephone Number

\_\_\_\_\_  
 Address City State Zip Code

**Official Use Only:** \_\_\_\_\_  
Name of Person Releasing Information Date