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

indentifiable health information of _____ **as described herein.**

Print Patient Name Date of Birth

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

Name/organization _____
Address _____
City, State, Zip _____

Phone _____ Fax _____

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

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

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**