SUNCOAST ORTHOPAEDIC SURGERY & SPORTS MEDICINE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

Name of Patient/Previous Names

Birth Date/Social Security Number

Street Address

City, State, Zip

AUTHORIZES MY CURRENT PHYSICIAN:

Physician Name

Street Address

City, State, Zip Code

TO RELEASE PROTECTED HEALTH INFORMATION TO:

Physician Name / Self

Street Address

City, State, Zip Code

INFORMATION TO BE RELEASED:

I hereby authorize you to release **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for information pertaining to**:

___Sexually transmitted disease
___Treatment of alcohol or substance abuse
___Records from other facilities/providers
___Testing or treatment of HIV/AIDS
___Communications between patient and psychotherapist for mental health treatment

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (check one)

___Further Medical Care
___Insurance/Eligibility
___Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Suncoast Orthopaedic Surgery & Sports Medicine will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Suncoast Orthopaedic Surgery & Sports Medicine will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I will be charged a charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP:_____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so.)

EXPIRATION DATE: This authorization is good until the following date(s)_____or for six months from the date signed.

Distribution of copies: Original to provider; copy to patient; copy to accompany released records 02-16-