PATIENT:

SUNCOAST ORTHOPAEDIC SURGERY & SPORTS MEDICINE
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Fax: 941-485-7495 or 941-492-4123

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: __All Records ___Visit notes ___X-ray reports ___X-ray Films____MRI

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
Testing or treatment of HIV/AIDS
Treatment of alcohol or substance abuse
Records from other facilities/providers

___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

02-16-07