CENTRAL FLORIDA ORTHOPAEDIC SURGERY ASSOCIATES, P.L.

Consent for Release of Medical Records

Central Florida Orthopaedic Surgery Associates, P.L.
Stuart D. Patterson, M.D.

Patient Name: _____ Medical Record Number: _____

DOB: _____ SSN: _____

Address: _____

Records Requested: (circle one) **TO / FROM** **FORM COMPLETION**

Provider: _____

Address: _____

_____

Fax #: _____ Attention: _____

☐ Complete Records

☐ Limited Release (Specify) _____

☐ Exclusions to Release (Specify) _____

PURPOSE OF DISCLOSURE: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release may no longer be protected by federal privacy. This release includes sexually transmitted disease records, TB records, HIV & AIDS related information, drug/alcohol records, psychiatric/psychological records, adult & child abuse and/or abortion records, unless specifically listed above as exclusion.

I hereby release Central Florida Orthopaedic Surgery Associates, P.L. and its employees, agents, officers & affiliates from any and all liability, responsibility, claims & damages which may result from the release of information authorized by this Consent for Release of Medical Records.

I understand that this release is subject to revocation at any time, except to the extent that action has already been taken. Unless otherwise stated below, this consent shall automatically expire in ninety (90) days from the date set forth below or upon the following date, event or condition: _____.

I have read and understand the Consent of Release of Medical Records authorization and have voluntarily and knowingly signed the release to acknowledge my consent. I understand that I may see and obtain a copy of the information described on this form if I ask for it (copy charges applicable) and that I request a copy of this form after I sign it (initial) _____.

DATE: _____ PATIENT SIGNATURE: _____

IF MINOR OR AUTHORIZED PATIENT REPRESENTATIVE (SIGN BELOW)
SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

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