

INSTITUTE FOR ORTHOPEDIC SURGERY AND SPORTS MEDICINE

Authorization for release of healthcare provider medical records and billing information.

Patients Name _____

Date of Birth _____ SS# _____

I hereby authorize: Institute for Orthopedic Surgery and Sports Medicine
8350 Riverwalk Park Blvd, #1
Ft Myers, FL 33919

to release the following information from my confidential record: (initial all that apply)

_____ the entire medical record	_____ admission/discharge summary
_____ follow-up/progress notes	_____ MRI, X-ray, lab reports, etc
_____ history and physical	_____ HIV/AIDS testing
_____ Psychiatric/psychological	_____ billing statements
_____ referral letters and consults	_____ physical therapy notes
_____ operative notes	_____ other _____

to: _____ (name)
_____ (address)
_____ (phone/fax)

I understand that authorizing the disclosure of my medical record is voluntary.

I understand that this authorization will expire one year from the date of signing unless a shorter time period is indicated.

I understand that I may revoke this authorization at any time by writing to the medical provider identified above. Revocation will not apply to information already disclosed.

I understand that information disclosed under this authorization may not be protected by federal privacy regulation if it is further disclosed by the recipient, who is not a health plan or health care provider.

Signature of Patient or Legal Representative (attach power of attorney) _____ date

Relationship to patient

I understand that there will be a charge of \$10.00 per x-ray sheet and I agree to pay for the x-ray at the time of pickup or prior to sending. Eff: 12-20-2006 all x-rays and MRI reports are available only on a CD. This cost for this is \$5.00.

There is also a charge for medical records released to patient. Smart Corporation copies and mails all records out and does charge for this service.