

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: *****Check which apply*****

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

Institute for Orthopedic Surgery and Sports Medicine
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, etc
_____ history and physical	_____ HIV/AIDS testing, Drug/Alcohol Records
_____ Psychiatric/psychological	_____ billing statements
_____ referral letters and consults	_____ physical therapy notes
_____ operative reports	_____ other _____

to: Institute for Orthopedic Surgery
and Sports Medicine
8350 Riverwalk Park Blvd, #1
Ft Myers, FL 33919
Phone: 239-482-5399
Fax: 239-482-4353

Name _____
Address _____
City, State _____
Zip _____

*****Check which apply*****

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.

I understand there is a cost to send records out of office. Bactus corporation releases all records with the exception of X-ray and MRI films. \$5.00 charge for disc which is done in office.

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

Relationship to patient

*****Office Use*****

Request to: Fax: _____ Pickup: _____ FM/E _____ Phone Pt when ready