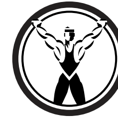
For the Finest Orthopedic Care

www.atlasortho.net



ATLAS ORTHOPEDICS
AND SPORTS MEDICINE

7975 Lake Underhill Rd.,
Suite 330,
Orlando FL. 32822

P. 407-381-8441
F. 407-381-8557

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Legal Name: ______________________ *Date of Birth:* ____________

Address: ______________________________________

SSN: ____________________ *Previous Name:* ____________________

RECORDS FROM: ______________________________________
(LIST ALL DOCTORS)

ADDRESS: ______________________________________

PHONE: ____________________ FAX: ____________________

SEND RECORDS TO: ______________________________________

ADDRESS: ______________________________________

PHONE: ____________________ FAX: ____________________

INFORMATION REQUESTED (INCLUDE DATES): ______________________________

WHAT IS THE PURPOSE OF THE USE OF DISCLOSURE OF INFORMATION?: ______________________________

READ THE FOLLOWING PRIOR TO SIGNATURE

- The original medical record is the property of Atlas Orthopedics and Sports Medicine.
- Medical records sent from another facility cannot be released.
- There is a minimum 10-day waiting period.
- There may be a fee for this service. Florida code Chapter 64B8-10 allows a health care provider to charge a reasonable fee for providing health care information, which may not exceed $1.00 dollar per page for a paper copy or photocopy. It also allows for a reasonable administrative fee that may not exceed $15.00 for searching and handling recorded health care information. I understand that it may be necessary for me to make payment in advance of receiving my records.
- I authorize any doctor, health care provider, hospital, clinic or medically related facility to release any personal information, including physical, mental, drug, or alcohol use, sexual assault, sexually transmitted diseases, including HIV history.
- I understand that this information is protected by Federal law and cannot be released without this consent.
- I understand that I may revoke this authorization at any time by notifying the providing orginization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- This authorization is only valid for 6 months from date os signature.
- You may refuse to sign this authorization.

You specifically have my permission to release this information if such as a part of my record.

______________________________________ ____________________
Signature of Patient or Responsible Party Date

Relationship to Patient: ______________________________