Medical Records Authorization for Release of Protected Health Information

The completed form may be returned to 6500 Bowden Road Ste. 103 Jacksonville FL 32216
or by fax to 904-634-0203

(Internal Medical Records Release Form)

Patient Name: _____ Date of Birth: _____
Social Security Number:_____
Address: _____ City: _____ State: _____
Zip Code:_____
Phone Number:_____ Alternate Phone Number: _____

I hereby authorize Southeast Orthopedic Specialists to release the following information contained in my medical records:

Medical Records:
___Initial Patient Paperwork / Questionnaires
___Office Notes (Dates:_____)
___Itemized Billing (Dates:_____)
___Physical Therapy Notes

Hospital Reports:
___Consult ___Operative Report
___History & Physical_____Discharge Summary

Diagnostic Imaging:
Body part of concern: _____
___X-ray Films / Disc
___Laboratory Tests
___Diagnostic Reports (Type:_____)

Other: _____
_____
_____

Release of records is for:___Attorney ___Physician ___Insurance ___Other

___**Pick up records** at: ___Riverside ___Center ONE ___Clay __Orange Park ___Ponte Vedra

___**Mail to**: (Name & Address)
_____
_____

_____

___**Fax records to**: (Name & Number)
_____
_____

I understand that I may revoke this authorization in writing at any time, except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. I hereby release Southeast Orthopedic Specialists from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released. **I acknowledge that I have read this authorization and fully understand its contents.**

Patient/Parent/Guardian: **Date: _____**
Signature:_____

Employee Name: _____ **Date: _____**