Authorization Request for Release of Protected Health Information

(Outside Medical Records Release Form)

Please specify where we are requesting records from: _____ Fax: _____

I hereby authorize the use or disclosure of health information as described below for continued healthcare TO:

Southeast Orthopedic Specialists

Return Medical Records to Fax Number: 904-634-0203

Requesting Physician: _____ Attention: _____

Patient Name: _____ DOB: _____

Social Security Number: _____ Phone Number: _____

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: _____

_____
_____

Patient/Parent/Guardian Signature:

_____

Date:

_____

Employee Signature:

_____

Date: _____

Mailing Address:
Southeast Orthopedic Specialists
6500 Bowden Road., Ste 103
Jacksonville, FL 32216
Email: Medicalrecords@se-ortho.com