Medical Records Authorization for Release of Protected Health Information

Mail Completed form to: 6500 Bowden Road Ste. 103 Jacksonville, FL 32216
Fax completed form back to: 904-634-0203
Email completed form back to: MedicalRecords@se-ortho.com

(Internal Medical Records Release Form)

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

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

Medical Records:
___Office Notes (Dates:_____)
___Itemized Billing (Dates:_____)
___Physical Therapy Notes(Dates: _____)

Diagnostic Imaging:
Body part of concern: _____
___X-ray Films / Disc (**$5.00 charge per CD**)
___Laboratory Tests
___Diagnostic Reports (Type:_____)

Hospital Reports:
___Consult ___Operative Report
___History & Physical_____Discharge Summary

Other: _____
_____
_____

Release of records is for: __Attorney ___Physician ___Insurance ___Other

I would like to receive the requested information by:

Mail: _____ Fax: _____
_____
_____ Email: _____

Patient Portal: Log in or Enroll at www.NextMD.com

Pick Up: (Please specify which location): _____

****If you do not print clearly, or neglect to indicate where to return the information to we will be unable to process your request in a timely manner****

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: Signature:_____
Date:_____