9240 Bonita Beach Road, Suite 2200
Bonita Springs, FL 34135
(Phone): 239-514-4200
(Fax): 239-514-3373

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

PATIENT NAME: ____________________________SOCIAL SECURITY# _____________________
ADDRESS: ____
DATE OF BIRTH: _____/_____/___________ DATE: __________________________
PHONE# _____________________________
TYPE OF IDENTIFICATION SHOWN: _____________________________

I HEREBY AUTHORIZE SAMOTIN ORTHOPAEDICS
___ TO USE AND DISCLOSE TO
___ OR OBTAIN FROM
___ OR ALLOW TO REVIEW

____ Phone _________________________
Name of Facility or Person Fax _________________________

____
Street Address City State Zip Code

SEND RECORDS TO: (Name of Facility or Person) ____

____
Street Address City State Zip Code
Fax # _________________________________

The following information contained in my medical record regarding my care and treatment (please initial):

____Complete Record ____All Diagnostic Test Results ____ Pathology Report(s)
____Lab only ____Therapy Records ____Radiology only
____Progress Notes ____Operative Report(s)

The purpose for the release of information at the request of the individual is:

____Insurance ____Legal Action ____Personal Use ____Continued Treatment
Other (please specify) ____

This authorization will expire on the following date, event, or condition: __________________________

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS, and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or other required by law.

May NOT include information related to (please initial):

____ HIV/AIDS ____Mental Health
____Drug/Alcohol Abuse ____Genetic Counseling/Testing Information

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Samotin Orthopaedics may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand I will receive a signed copy of this form.

____
Patient/Legal Representative or Parent/Legal Guardian Signature Date

- I wish to revoke this authorization Signature ______________________ Date: _____________