NAME _____

DATE OF BIRTH _____ ACCOUNT # _____

JEWETT ORTHOPAEDIC CLINIC, LLC

Authorization for Obtaining Outside Records and/or Diagnostic Films

If you have had previous medical treatment and/or diagnostic testing for orthopaedic problems, please complete the following release. This will assist us in obtaining these records and/or films for review by our physicians/physician extenders. You understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Name of Facility: _____

Address of Facility: _____

_____

Phone # _____ Fax # _____

Description of Information to be released (check all that apply)

☐ Medical data/information as related to: ☐ X-ray films as related to:

- ☐ Specific condition(s) /specific physician(s): _____
- ☐ Specific time frame(s): _____
- ☐ All office notes, test results, and/or films: _____
- ☐ Other: _____

Reason for request: Medical Treatment _____ Legal _____ Other _____

Please send copies of my medical records and/or diagnostic tests/films to:

Jewett Orthopaedic Clinic, LLC

☐ **Winter Park Office** 1285 Orange Avenue, Winter Park, FL 32789	407-647-2287	Fax: 407-643-1303
☐ **Lake Mary Office** 701 Platinum Point, Lake Mary, FL 32746	407-206-4500	Fax: 407-829-2563
☐ **Sandlake Office** 7300 Sandlake Commons Blvd #127, Orlando, FL 32819	407-345-1646	Fax 407-351-2908
☐ **University Office** 3451 Technological Ave # 15, Orlando, FL 32817	407-380-8705	Fax 407-381-1971
☐ **Downtown Office** 1717 South Orange Ave #103, Orlando, FL 32806	407-236-0404	Fax 407-236-0402
☐ **RDV Sportsplex** 8701 Maitland Summit Blvd., Orlando, FL 32810	407-916-4120	Fax 407-916-4110
☐ **Orthopaedic Convenient Care** 801 S Orlando Ave. Winter Park, FL 32789	407-599-3710	Fax 407-599-3711
☐ **East Orlando Office** 7975 Lake Underhill Road #330, Orlando, FL 32822	407-381-8441	Fax 407-381-8557
☐ **Ocoee** 596 Ocoee Commerce Parkway Ocoee, FL 34761	407-654-3505	Fax 407-643-2809
☐ **Kissimmee** 601 East Oak Street – Suite A Kissimmee, FL 34744	407-654-3505	Fax 407-643-2810

This authorization expires on [upon] _____ *[Insert applicable date or event,*

i.e. - completion of treatment for this medical condition

I understand that I may inspect or obtain a copy of the information used or disclosed.
I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that action has been taken in reliance on the Authorization.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) **PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)**

Date: _____

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

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