Authorization for Disclosure of Health Information

I, the undersigned, authorize FL413: Jewett Orthopaedic Clinic: WP: Main1285 Orange Avenue Winter Park, FL 32789 to release my health information as noted below:

Patient Information

JOC ACCOUNT # : _____

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released

Unless otherwise specified, only the following information will be released:

Abstract includes most recent, up to 2 years: Medical History, Progess Notes, Lab results, Reports of Consultations and Operative Reports.

☐ Please provide an abstract of my records
Copy fee capped at $15.00 for up to 2 years

☐ Other - please be specific under comments
*Over 2 yrs, will be charged per Florida Statute. See below
Records Requested: _____
_____
_____

**FloridaStatute Copy Fee: $1.00 per page for first 25 pages, $.25 for any pages over 25, plus postage.*

PAYMENT OPTIONS:

CHECK - Please make check payable to BACTES Imaging Solutions.

CREDIT CARD - Please provide an email address to have invoice sent. If you do not have an email, a invoice will be mailed to address provided under the patient information above.

Email: _____

*****Requests for copies of Radiology Films/CD's are processed and invoiced by Jewett Orthopaedic Clinic. A separate form is required and any fees for Radiology copies are payable to JOC.***

Authorization to Release Protected

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released _____
"Other sensitive information?"

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Jewett Orthopaedic Clinic and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*