ORLANDO PHYSICAL THERAPY

2014 South Orange Avenue, Suite 200-B
Orlando, Florida 32806
668 N. Orlando Avenue, Suite 1010
Maitland, FL 32751
Phone: 407-273-3100 Fax: 407-273-3102

Authorization to Obtain, Release or Review Protected Health Information

Please fax records to:

Today's Date 06 / 23 / 13 **DOB** 3 / 44 / 13 **SS #** 333 / 22 / 1111

Patient Last Name _____, **First Name** _____

Specific type of information to be disclosed:
(The AUTHORIZED person must initial below, next to the type of information to be disclosed.)

Facility _____ **Dr.** _____ **DOS** ____/____/____

☐___ Complete Medical Record ☐___ Discharge Summary ☐___ ER Report
☐___ Medical Evaluation / Progress Notes ☐___ X-ray ☐___ MRI Reports
☐___ Laboratory Results ☐___ Psychiatric Evaluation
☐___Other (describe records required) _____

I, _____ hereby authorize the physician, his/her authorized designees or medical records personnel, hospital, laboratory or diagnostic center to release my identified protected health information including alcohol and drug abuse records under the regulation in Title 42 C of the Federal Regulations. Part 2 (if any); behavioral medical services record (if any), including communications made by me (the patient) to a social worker or psychologist; and, any information regarding communicable disease and infections as defined by MCLA 333.5131 (if any), which includes venereal disease, tuberculosis, HIV/AIDS, to individuals or organizations listed above, only under conditions listed below:

I understand that my protected health information disclosed under this authorization may be subject to re-disclosure by the individual(s) or organization(s) named above and my (the patient) protected health information will no longer be protected by the law. This authorization is to be used by the physician and will not condition treatment or payment on this authorization. This authorization can be revoked, in writing, at any time except to the extent that information has been released or disclosed. In order for the revocation of this authorization to be effective, the revocation must be in writing and delivered via certified mail. The revocation must include the patient's name, address, social security number, the effective date of this authorization, the patient's desire to revoke this authorization, the date of the revocation and the patient's signature. Authorization for release of disclosure of drug and/or alcohol abuse records shall end when the purpose of the release has been achieved.

Patient's Signature _____

Patient/Legal Representative or Parent/Legal Guardian Signature _____

This authorization will expire (six (6) years from the date signed above).

Submit Reset This Form