SOAR
SPINE • ORTHOPEDICS • AND • REHABILITATION
A Prospira PainCare Center of Excellence
www.soarflorida.com

Spine, Orthopedics and Rehabilitation

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First Middle

Patient's Address: _____ City _____State _____ Zip _____

Home/Business Phone _____ Cell Phone: _____ E-Mail: _____

PERSON OR ENTITY TO RELEASE INFORMATION

☐ **Spine, Orthopedics and Rehabilitation**

☐Name: _____

Address: _____

Phone: _____

Fax: _____

PERSON OR ENTITY TO RECEIVE INFORMATION

☐ **Spine, Orthopedics and Rehabilitation**

☐Name: _____

Address: _____

Phone: _____

Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

____ Complete Medical Record ___Office Notes ___ Lab Reports

____ Procedure Reports ___ Surgery Records ___ Billing Records

_____ Other (Specify)

FEE FOR COPIES

***For Personal Use*: No charge**

***For Continuing Care*: No charge when we email or fax.**

***For Work Comp*: $.50 per page.**

***For Personal Injury*: $1.00 per page up to 25 pages. Over 25 pages $.25 cents per page(per Florida law).**

DATES OF SERVICE: _____

METHOD OF DELIVERY: ____ Paper Copy ____ Electronic Copy

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance.
___ Workman's Compensation, ___ Other _____

This authorization will expire on _____. (If no date specified, this authorization shall expire 1 year after date signed.)

CHECK AND INITIAL BELOW:

___ I DO, ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto. *(Initials of individual giving authorization)* _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**. (*Initials of individual giving authorization)* _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment. *(Initials of individual giving authorization*) _____.

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and/or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient (if applicable, attach document of guardianship or Power of Attorney) Date

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