AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Who are you requesting records from? (Facility/Doctor) **NOT PhotoStat, enter the responsible medical facility or doctor's office.

Facility Name: Florida Joins & Spine Institute

Street Address: 400 Avenue K SE City: Winter Haven State: FL Zip: 33880

Whose records are you requesting? (Patient)

First Name: _____ Last Name: _____ Date of Birth: _____

SS# (last 4 digits): _____ Cell Phone: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date(s) of Treatment: _____

Who are you sending your records to?

First Name: _____

Fax: _____ Cell Phone: _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

What information should be released?

- ☐ Discharge Summary
- ☐ Face Sheet
- ☐ Pathology Report
- ☐ Complete Chart
- ☐ Lab Reports
- ☐ Radiology Films
- ☐ Blood Type
- ☐ Radiology Reports
- ☐ History & Physical
- ☐ Abstract/Basics
- ☐ Progress Notes
- ☐ Itemized Bill
- ☐ ER Records
- ☐ Consultation Reports
- ☐ EKG/ECHO
- ☐ Operative Record
- ☐ Other _____

Why is this information being released?

- ☐ Patient Request
- ☐ Insurance
- ☐ Attorney
- ☐ Social Security
- ☐ Treatment/Consultation
- ☐ Other _____

SUBSTANCE USE/ABUSE TREATMENT, PSYCHIATRIC, GENETIC TESTING, AND/OR HIV/AIDS RECORDS RELEASE

Federal and State law requires specific authorization from patients to release sensitive information. I understand that if my medical or billing record contains information in reference to drug, tobacco and/or alcohol use/abuse, psychiatric care, genetic testing, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I must specifically agree to its release by checking Yes or No in the appropriate box. (TX HB 300)

Substance use or abuse:
- ◯ YES - Disclose
- ◯ NO - Do NOT Disclose

Psychiatric Care/mental health records:
- ◯ YES -Disclose
- ◯ NO - Do NOT Disclose

Genetic Testing:
- ◯ YES - Disclose
- ◯ NO - Do NOT Disclose

HIV/AIDS testing and/or treatment:
- ◯ YES -Disclose
- ◯ NO- Do NOT Disclose

TIME LIMIT & RIGHT TO REVOKE

I understand this authorization will be valid for 180 days from the date signed to release any records created up to the date of signature unless revoked prior to that time or unless otherwise specified as follows. Any records created after the date of this authorization will require a new. Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address.

I desire this authorization to be in effect until _____(expiration date/event).

AUTHORIZATION & RE-DISCLOSURE

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my healthcare may not be conditioned on whether I sign this authorization form. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal and state privacy regulations. I authorize the medical facility to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for reproduction of record copies and/or CD's. A copy or facsimile of this authorization is as valid as the original.

_____ _____

Signature of Patient Date