AUTHORIZATION OF RELEASE OF INFORMATION
TO TALLAHASSEE ORTHOPEDIC CLINIC ("TOC")

3334 Capital Medical Blvd. Tallahassee, FL 32309 | Fax# 844-261-6839

Patient's Name: (Last) (First) (Initial) (Date of Birth) (Social Security Number)

Address: (Street) (City) (State) (Zip)

Home Telephone **Work Telephone**

I authorize the following entity ("Releaser") to disclose and release Patient's **Protected Health Information** ("PHI") from Patient's **Medical Record** to Tallahassee Orthopedic Clinic (the "Releasee"):

Name of Releaser - Doctor, Hospital, Agency, etc. **Telephone** **Facsimile Number**

Address: (Street) (City) (State) (Zip)

Releaser is authorized to disclose and release the specific **PHI** from the Patient's **Medical Records**:

_____ Any and All _____ Consultations _____ Developmental Disabilities _____ X-ray Reports
_____ Medical History, Examination Reports _____ Hospital Records, Including Reports
_____ Laboratory Reports _____ Treatment or Tests _____ Prescriptions _____ Surgical Reports
_____ Allergy Records _____ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

( ) Yes, I consent to the release of this information.
( ) No, I do not consent to the release of this information.

Releaser is authorized to disclose and release the Patient's **PHI, as specified above**, to the **Releasee** for the specific use(s) or purpose(s) of:

_____ Further treatment/care _____ Legal _____ At the Request of the Individual
_____ Other: _____

This authorization will expire on _____. If no date is specified, this authorization shall expire one year after the date it is signed by the Patient or the Patient's legal Representative.

I understand that:

- the PHI disclosed pursuant to this authorization may be subject to redisclosure by the Releasee (the recipient) and may no longer be protected by the federal Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
- I may revoke this authorization, at any time, upon the written request to TOC's Privacy Officer, except to the extent that action has been taken in reliance of this authorization.
- I have the right to receive a copy of this authorization.
- treatment may not be conditioned on the signing of this authorization, and its signing is voluntary.

I have fully read and understand the nature of this Authorization and accept its terms. I authorize TOC, the Releaser, to disclose and release the specific PHI, as indicated, to the Releasee, as listed, for the specific use(s) and purpose(s) listed.

Patient's/legal Representative's* Signature **Date**

***State relationship to patient and attach applicable documents for guardianship and Power of Attorney.**

Witness **Date**

(7/2018) JLP