Authorization for the Release of Medical Records

West Orange Orthopaedics & Sports Medicine

Date: _____

Patient Name: _____ Phone #: _____

Date of Birth: _____ SS#:_____

Patient Address: _____

_____

I authorize **WEST ORANGE ORTHOPAEDICS** release medical information from my medical records to:

Name of Physician/ Hospital: _____

Address: _____

_____

Phone: _____

SPECIFIC DOCUMENTS TO BE RELEASED:

(☐) ALL Records (☐) X-Ray Films (☐) Discharge Summary
(☐) Operative Reports (☐) History & Physical (☐) AIDS/ HIV
(☐) Psychiatric (☐) Drug/ Alcohol (☐) Other: _____

(☐) Lab/ Radiology Reports (☐) Progress Notes

(☐) Specific Date (s) of service: _____

(☐) Hand Carry (☐) Mail (☐) FAX

PURPOSE FOR INFORMATION:

(☐) Continued Medical Care (☐) Second Opinion (☐) Insurance (☐) Attorney (☐) Personal

This request is authorized to include any federal and/ or state protection under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/ or 397.50(3) records of minor client.

NOTE TO REQUESTING PARTY: Florida statue has established guidelines and cost rates for the copying of records. Your signature on this form indicates your knowledge of this statement.

I hereby release **WEST ORANGE ORTHOPAEDICS**, and its employees, agents, officers and affiliates, from any and all liability, responsibility, claim and damages which may result from the release of information authorized by the consent for release of information.

SIGNED: _____ Date: _____
(If not patient, state relationship-Must provide Power of Attorney and/or Legal Guardianship)

Form of ID verified: _____

Witness: _____ Date: _____