**Central Florida Orthopaedic Surgery Associates, PL**
CONSENT FOR RELEASE OF MEDICAL RECORDS

Record Number: ________________________________________________
Patient Name: ___________________________ DOB: ________________
Address: ______________________________________________________

## MEDICAL RECORDS REQUEST

Records Requested by:
Stuart Patterson, M.D.
Central Florida Orthopaedic Surgery Associates, PL
2000 East Edgewood Drive, Suite 112
Lakeland, FL 33803 PH: (863) 666 – 3436 FAX: (863) 667-3550

## MEDICAL RECORDS RELEASE

Release Medical Records From:
Provider: ______________________________________________
Address: _______________________________________________
_______________________________________________
Phone #: ________________ Attention: ________________________

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_ Complete Records
_ Limited Release (***Specify***) ____________________________________
_ Exclusions to Release (***Specify*)** _______________________________
**PURPOSE OF DISCLOSURE**: _________________________________________

I hereby authorize the use or disclosure of my individually, identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release may no longer be protected by federal privacy. This release includes sexually transmitted disease records, TB records, HIV & AIDS related information, drug/alcohol records, psychiatric/psychological records, adult & child abuse and/or abortion records, unless specifically listed above as exclusion.

I hereby release *(releaser of records)* ______________________________and its employees, agents, officers & affiliates from any and all liability, responsibility, claims & damages which may result from the release of information authorized by this Consent for Release of Medical Records.

I understand that this release is subject to revocation at any time, except to the extent that action has already been taken. Unless otherwise stated below, this consent shall automatically expire ninety (90) days from the date set forth below or upon the following date, event or condition: ____________________________.

I have read and understand the Consent for Release of Medical Records authorization and have voluntarily and knowingly signed the release to acknowledge my consent. I understand that I may see and obtain a copy of the information described on this form if I ask for it (*copy charges applicable*), & that I may request a copy of this form after I sign it (*initial*) ________.

DATE: ________________ PATIENT SIGNATURE: ________________________________________

***IF MINOR OR AUTHORIZED PATIENT REPRESENTATIVE (SIGN BELOW)***
SIGNATURE OF AUTHORIZED REPRESENTATIVE: _______________________________________
RELATIONSHIP TO PATIENT: _________________________________________________________