

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

Please Print Clearly

\_\_\_\_\_  
**Patient's Name:** (last) (first) (initial) (Date of Birth) (Social Security Number)

\_\_\_\_\_  
**Address:** (street) (city) (state) (zip)

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
**Home Telephone** **Work Telephone**

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

\_\_\_\_\_  
**Name of Releasee - Doctor, Hospital, Agency, etc.** (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
**Telephone** **Facsimile Number**

\_\_\_\_\_  
**Address:** (street) (city) (state) (zip)

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

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

**INITIAL:** \_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT** authorize **TOC** to release or disclose any information pertaining to the Human Immunodeficiency Virus ("HIV") which is the causative agent of Acquired Immune Deficiency Syndrome ("AIDS"), including, but not limited to specific laboratory tests, test results, the diagnosis of AIDS or HIV or any related conditions and any and all medical records and clinical information relating to the evaluation, diagnosis and treatment relating to **HIV, AIDS or any related conditions**.

**INITIAL:** \_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT** authorize **TOC** to release or disclose any information, including but not limited to the medical records and clinical information pertaining to the assessment, evaluation, treatment and/or hospitalization related to **mental health or psychiatric** illnesses or conditions.

**INITIAL:** \_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT** authorize **TOC** to release or disclose any information, including but not limited to the medical records and clinical information pertaining to the assessment, evaluation, treatment and/or hospitalization for any **drug, alcohol or substance abuse or use**.

**TOC** 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**