

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:

<input type="checkbox"/> Any and All	<input type="checkbox"/> Hospital Records, Including Reports	<input type="checkbox"/> Developmental Disabilities
<input type="checkbox"/> Medical History, Examination Reports	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Treatment or Tests	<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Consultations
<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Allergy Records		

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