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RELEASE OF INFORMATION

PATIENT NAME \_\_\_\_\_ D.O.B \_\_\_\_\_ SS# \_\_\_\_\_

I AUTHORIZE CITRUS ORTHOPAEDIC & JOINT INSTITUTE TO RELEASE INFORMATION TO

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

REASON FOR DISCLOSURE: \_\_\_\_\_

I UNDERSTAND THAT THIS AUTHORIZATION RELEASES MY GENERAL MEDICAL INFORMATION AS WELL AS INFORMATION CONCERNING MY PSYCHIATRIC TREATMENT. I ALSO UNDERSTAND THAT IF MY MEDICAL INFORMATION CONTAINS TREATMENT NOTES, DIAGNOSIS, AND/OR TEST RESULTS OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), HIV AND/ OR RELATED CONDITIONS, AND/OR SUBSTANCE ABUSE, THESE MEDICAL RECORDS SHALL ALSO BE RELEASED.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE MY CONSENT AT ANY TIME BY DELIVERY OF WRITTEN NOTICE TO THE PROVIDER RELEASING THE INFORMATION. CANCELLATION WILL BE EFFECTIVE UPON THE DATE THE NOTICE IS RECEIVED BY THE PROVIDER BUT WILL EXCLUDE INFORMATION ALREADY FURNISHED TO THE RECIPIENT BEFORE THE DATE.

Signature of Patient or Legal Representative \_\_\_\_\_ DATE \_\_\_\_\_

Relationship to Patient (if legal representative) \_\_\_\_\_ DATE \_\_\_\_\_

To recipient of information: This information is disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations, CRF Part 2 and Florida Statutes prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Mailed \_\_\_\_\_ DATE / INITIALS \_\_\_\_\_ FAXED \_\_\_\_\_ DATE / INITIALS \_\_\_\_\_ Given to Pt. \_\_\_\_\_ DATE / INITIALS \_\_\_\_\_