Once Forms are complete, please send to forms@citrusortho.net or send via a portal message or fax to 352-746-6907 for expedited service or bring to appt.

P O Box 1990
Crystal River, FL 34423
352-746-BONE (2663)
Fax: 352-746-6907

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 RECIPENT 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 confidentially is protected by Federal Law. Federal regulations, CRF Part 2 and Florida Statues 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_____ **FAXED_____** **Given to Pt._____**
DATE / INITIALS **DATE / INITIALS** **DATE / INITIALS**