OHSA
Orlando Hand Surgery Associates

801 N. Orange Ave, Suite 600, Orlando, FL 32801

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ **Date of Birth:** _____
Social Security #: _____

Purpose/Need for Information:

☐ Application for Insurance ☐ Changing Physicians ☐ Personal

☐ Regarding Insurance Claim ☐ Specialist

Specific Documentation Required:

☐ Office Notes ☐ Other _____

☐ Laboratory Reports _____

☐ X-Ray Reports _____

Information Requested From:

_____
_____
_____

Forward Documentation To:

_____
_____
_____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me during the period: FROM_____ TO _____.

☐ **PLEASE DO NOT FAX RECORDS**

This request is authorized to include and Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and/or Alcohol Abuse Information, 381.609 HIV and Aids related conditions and/or 397.501(3) records of a minor client.

I understand this authorization will expire 90 days from the date of signature below or when accepted upon, whichever event occurs first. I hereby release to the forwarding addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

_____ _____
(Signature or parent/guardian) (Witness)

_____
(Relationship to Patient)