OHSA
Orlando Hand Surgery Associates

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ **Date of Birth:** _____

Purpose/ Need for Information:

- ☐ Application for Insurance
- ☐ Changing Physicians
- ☐ Personal
- ☐ Regarding Insurance Claim
- ☐ Specialist

Specific Documentation Required:

- ☐ Office Notes
- ☐ Laboratory Reports
- ☐ X- Ray Reports
- ☐ Other:_____

Information Requested From:

Name: _____Phone#_____
Address: _____ Fax # _____

Forward Documentation To:

Name: _____Phone#_____
Address: _____ Fax # _____

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 the 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 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 representative from any and all liability that may arise from the release of information as I have directed. I understand if records are mailed to the patient's address or printed for pick up, there will be a charge for this. Our office will contact you with this fee.

_____ _____
(Signature of Parent/ Guardian) (Witness)

_____
(Relationship to Patient)

(FF4/2019)