COASTAL ORTHOPEDICS

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

To avoid delay in processing your request, this form must be completed in its entirety

Patient Information

Full Name: _____ Date of Birth: _____

Phone #: _____

Where are the records being released from?

☐ Coastal Orthopedics

☐ Outside Facility

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Where are we sending records? (Select 1 option and complete subsection)

☐ Patient Portal *Office notes and reports only* – ***Free of charge***

E-Mail Address for Portal Registration: _____

We can only send documents to active portals. If you are not active, please provide your e-mail address to obtain a registration link. Once registered, we can complete your records request.

☐ E-Mail – ***Free of charge***

E-Mail Address: _____

☐ Pick up at Coastal Location (Select location for pick up) – ***See associated fees below***

☐ Pointe West ☐ Highway 64 ☐ Lakewood Ranch

☐ Mail (Residential) – ***See associated fees below***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ Mail (Business) – ***No fee if sending directly to another physician's office***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

What would you like released? Check all that apply.

☐ Office notes ☐ Therapy notes ☐ Operative reports ☐ Imaging reports

☐ E-Mail Imaging ***No Fee*** ☐ Imaging CD ***See fee below*** ☐ Dates _____ to _____

☐ Other _____

_____ ***(Initial)***

Note: *If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Medical Records Fee

Coastal Orthopedics follows Florida Rule 64B8-10.003 regarding charging for medical records.

- For the first 25 pages, the cost shall be $1.00 per page. Pages in excess of 25 pages, the cost shall be 25 cents each.
- Records exceeding 100 pages will be delivered in a PDF format on a CD for $45
- Imagining CDs shall cost $15 per CD

Signature

I hereby authorize Coastal Orthopedics to use or disclose/dispense my health information to the person(s) or organization listed above. I understand this authorization is valid for 60 days. I understand that I have the right to revoke this Authorization at any time. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. Further, I acknowledge that the fees incurred by producing a copy of my medical records is my responsibility and will be applied to my account, payment is due at time of pickup.

Patient/Authorized Representative: _____ Date: _____

Authorized Representative Relationship to Patient: _____