



COASTAL ORTHOPEDICS AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

To avoid a 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
- Obtain records from Outside facility - **PLEASE INCLUDE FAX NUMBER**
 Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____ **FAX#** _____

If Coastal is sending records, where are we sending records? (Select 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: _____
If emailing to a business, please also include the mailing address and phone number:
 Name of business: _____
 Address: _____ Ph# _____
 City: _____ State: _____ Zip: _____
- Pick up at Coastal Location (Select location for pick up) **See associated fees below**
 West Bradenton East Bradenton/SR64 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 of Business: _____ Fx# _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone #: _____

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 _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer (Initial) 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 has already 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: _____