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?

☐ 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: _____

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

☐ West Bradenton ☐ East Bradenton/SR64 ☐ Lakewood Ranch

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**
- **Imaging CDs shall cost $15 per CD**

What would you like released? Check all that apply.

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

☐ Imaging CD ***$15 Fee*** ☐ Dates _____ to _____

☐ Other _____

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.*

(Initial) _____

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: _____