North Orlando Surgical Group, Inc.

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2864 Wellness Ave., Suite 200 Orange City, FL 32763
Phone: 386-775-0333 Fax: 386-775-0427

Authorization for use or disclosure of protected health information

Patient Name: ______________________ Soc. Sec.#: ______________

Address: ______________________ Date of Birth: ______________

Telephone: ______________________

Send information to:

Name: North Orlando Surgical Group, Inc
Attention: Telephone: 386-775-0333 Fax 386-775-0427 ______________
Address: 2864 Wellness Ave Suite 200
City: Orange City State: __**FL**______ Zip: __**32763**________

Purpose of release: ______________________

Requesting records from: ______________ Fax #: ______________

☐ Cardiovascular reports ☐ EKG report ☐ Laboratory results ☐ Pathology report ☐ Computer access HCA
☐ Radiology Reports ☐ History & Physical ☐ Operative Report ☐ Discharge Summary ☐ Computer access FHFM/FHD
☐ Emergency Room ☐ Other ______________________

Needed for doctor's appointment on: ______________

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.

As required by state and federal law, North Orlando Surgical Group, Inc. may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that this authorization will remain in effect for one year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to health information and record management North Orlando Surgical Group, Inc. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that North Orlando Surgical Group, Inc. cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and obtain a copy of any information disclosed.

I hereby release North Orlando Surgical group, Inc. and its employees from any and all liabililty that may arise from the release of information as I have directed.

I hereby authorize North Orlando Surgical Group, Inc. to release health information as directed above.

Patient's Signature: ______________________ Date: ______________

Signature of parent/guardian: ______________________ Date: ______________