Authorization to Disclose Health Information

VERO ORTHOPAEDICS NEUROLOGY

I, the undersigned, authorize
FL444: VERO ORTHOPAEDICS / VERO NEUROLOGY
1155 35th Lane, Suite 100
Vero Beach, FL 32960
to release my health information as noted below:

Patient Information:

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Continuation of Care ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Charges will be applied at reasonable cost for all copies released. Charges do not apply when the records are being sent directly to a healthcare provider for continuation of care with the exception of records being transferred to a physician who has left our practice, then charges will apply

Information to be Released:

Unless otherwise specified, only the following information will be released:

Abstract includes most recent, up to 2 years: Medical History, Progress Notes, Lab Reports, and Diagnostic Testing.

☐ Please provide an abstract of my records for **$15.00** plus HIPAA labor and material cost for up to 2 years.

☐ Other - please be specific under comments
*Over 2 yrs, will be charged per the Patient Directive Fees.
Comments: _____
_____

☐ Please provide a disk of my radiology images for **$9.00**

**Patient Directive Fees vary based on page counts and delivery methods.*

☐ **Please check here if you would like your records sent electronically.**
Email Address:
_____

☐ **Please check here if you would like yours records sent by mail.**

☐ **Please check here if you would like your records sent on a CD.**

PAYMENT OPTIONS:

CHECK: Please make checks payable to BACTES Imaging Solutions.

CREDIT CARD: Please provide an email address to have an invoice sent. If you do not have an email address, an invoice will be sent to your mailing address .

Authorization to Release Protected:

***Required** - Please read and complete. Check the boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released _____
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released _____
"Other sensitive information?"

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____**Date:**_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian _____**Date:** _____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Vero Orthopaedics/Vero Neurology and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*