

THE STRENGTH OF EXPERIENCE

Authorization to Disclose Protected Health Information

The undersigned authorizes Vero Orthopaedic Neurology

Fax: (772) 562-9460

to release my health information as noted below:

All sections must be completed in order for request to be processed

Patient Information	
Patient Full Name:	Date of Birth:
Patient Address:	Other Names?
City: State:	Zip: Phone #:
Release Information To (THIS SECTION MUST BE COMPLETED)	
Email address for record delivery: Please ensure email address is legible!	
You must provide a valid email address and name of your designated recipient in	f electronic delivery is chosen.
Name/Facility:	Attention:
Address:	Phone:
City: State:	Zip: Fax #:
Purpose of Request: ☐ Personal ☐ Treatment ☐ Lega	I □ Insurance □ Transfer □ Other:
Information to be Released (THIS SECTION MUST BE COMPLETED) If you fail to specify, 1 year of records will be provided.	
Office Labs Operative Diagnostic Radiology Notes Reports Images	Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies. At no time will the cost-based fees exceed FL law (395.3025 (1))
Specify Date(s) of Service:	I understand I will be responsible for the charges incurred in the release of my protected health information.
Body Part:	Rates are determined by Delivery Method Selected. *** PAYMENT OPTIONS: Check, Credit Card or Money Order
☐ Other (please specify):	DELIVERY [] Send by [] Mail Records [] Mail Records on CD on Paper
Questions about your request or invoice can be answered by calling: Sharecare Health Data Services at 877-548-4069	*A valid email must be provided above. If you do not select a delivery method, Sharecare will determine the delivery method based on the information provided on this form. No charge for records being released to another healthcare provider with the exception of records being transferred to a physician who has left our practice, then charges will apply.
Authorization to Release Protected Health Information	
I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* (Please Initial)	
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition:	
Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.	
Signature*:	Date:

^{*} For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.