

Jacksonville Orthopaedic Institute  
410 Jacksonville Drive  
Jacksonville Beach, FL 32250  
Fax: (904) 241-4970 Attention: Beth

**PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**I hereby consent to the release and disclosure of my personal health information to:**

Name ( Individual or Organization): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

For the following purpose(s):

- |   |   |
|---|---|
| <input type="checkbox"/> Continuing Medical Care      | <input type="checkbox"/> Personal Use             |
| <input type="checkbox"/> Information for Insurance Co | <input type="checkbox"/> Information for Attorney |
| <input type="checkbox"/> Other (please specify) _____ |   |

This authorization for release includes **copies** of my personal health information consisting of:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Initial Evaluation   | <input type="checkbox"/> Operative Reports                | <input type="checkbox"/> Medical Status |
| <input type="checkbox"/> Progress/Office Notes  | <input type="checkbox"/> Discharge Summary                | <input type="checkbox"/> Work Status    |
| <input type="checkbox"/> X-ray/MRI films <b><u>\$10.00 prepay for each film copied. CASH required. NO checks, credit or debit cards</u></b> |   |   |
| <input type="checkbox"/> <b><u>X-ray/MRI films will not be mailed. Pick up only</u></b>   |   |   |
| <input type="checkbox"/> Other (please specify) _____   |   |   |
| <input type="checkbox"/> Mail to above  | <input type="checkbox"/> Call for pick up - Phone # _____ |   |

*I understand that the information outlined in this release will be disclosed according to the instructions of this release within five to seven (5-7) business days of JOI - Beaches having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F. R. 164).*

**This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely by patient or legal representative.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or Parent of minor child or Legal Personal Representative)

DOB: \_\_\_/\_\_\_/\_\_\_\_\_

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FOR OFFICE USE ONLY: **CHART #** \_\_\_\_\_ **DR L W Y VT** (circle)

**REVOCAATION:** This authorization was revoked on \_\_\_/\_\_\_/\_\_\_\_\_(date) letter attached