ORTHOPAEDIC & SPORTS MEDICINE CENTER OF MIAMI, P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & INFORMATION

Patient Name: ______________________________ Social Security #:______________________

Guarantor Name ____________________________ Guarantor SS#: _______________________

Address: __________________________________ City/State ______________ Zip _________

I hereby authorize the release of medical information:

To/ From:

Orthopaedic & Sport Medicine Center of Miami 6701 Sunset Drive, Suite 201 Miami, FL 33143 Phone: 305-661-7601 Fax: 305-661-0154

To/From:____

Telephone: ___________________ Facsimile: ____________________

Specific Information Needed:

____ Medical Notes/ Summary ____ X-Ray Report ____ MRI Report ____ CT Report
____ Operative Report ____ Complete Medical Records ____ Billing Receivable
Other: __________________________

Purpose for This Disclosure: (Optional)

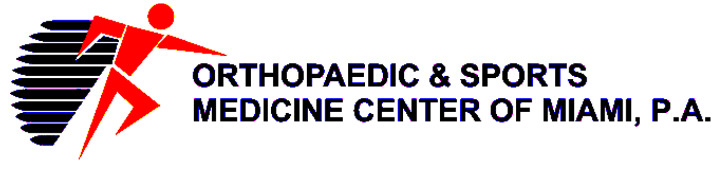
____ Continuing Medical Treatment ____ Insurance ____ Attorney

____ Consultation / Primary / Physician Other (List Name): ____________________ ____ Other (please specify)

____ I UNDERSTAND that I have the right to a copy of paper records or to inspect the disclosed information if so requested. All medical records given directly to the patient will be copied except for copies of x-rays, at which a prepayment of $10.00 per sheet will be required. Original films are required to stay on the premises of the record custodian of Orthopaedic & Sport Medicine Center of Miami. For additional copies to the patient, charges will be assessed. I UNDERSTAND this information may be faxed, hand-carried, e-mailed, texted or mailed, (rates for postage and handling may be assessed), and persons other than those it is intended may have access to it. This release expires six months from the date noted below, or earlier by written request. I have the right to revoke this request, if the revocation is submitted in writing. I HEREBY RELEASE THE ABOVE LISTED FACILITY, ITS EMPLOYEES, STAFF AND AGENTS FROM ALL LEAGAL RESPONSIBILITIY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY MEDICAL RECORDS.

SIGNATURE: ____ DATE: __________________

Information sent by: ____________________DATE: __________________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