KEY WEST ORTHOPEDICS, P.A.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize _____to release

To: _____

_____

The following information from my medical record:

____ Entire Medical Record
____ History & physical
____ Progress Notes
____ Problem List
____ H.I.V. Records
____ Other (Specify) _____
____ Medication List
____ Operative List
____ Pathology Report
____ Dx Test Results (Lab or Radiology)
____ Psych Records

Regarding: Patient Name: _____

D.O.B: _____

The purpose or need for the information is:

____ Continuity of care
____ Other (Specify) _____
____ Reimbursement

I understand that this authorization is valid for 90 days (Note: subject to legal counsel and State Law) after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with it. Information documented in my record after the date of my signature will not be released.

_____
Date

_____
Signature of Patient or Legal Representative

_____
Legal Representative's Relationship to Patient

_____
Copied/Pulled Date & Initials

_____
Date of Pickup/Faxing/Mailing & Initials