ORTHOPEDIC CENTER
OF TITUSVILLE

"Restoring Function"

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about be, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name:_____ DOB:_____

Phone: _____

I hereby authorize: _____

Phone:_____ FAX:_____

To disclose information from my/minor child's medical records to:

Name: _____

Address: _____

City: _____ State: _____ ZIP:_____

Phone:_____ FAX:_____

This information is needed for the following reason:_____

The specific information I wish to have released is (included dates of treatment):_____

_____

HIV/AIDS: I **DO** ___ **DO NOT** ___ consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:**_____ **Date:** _____

I understand that I may revoke this consent at any time, except where the information has already been released. This authorization is valid for one (1) year period from the date it is signed.

Signature: _____ Date: _____

(Patient signature (or parent, guardian, or legal rep.)

Relationship to patient:_____

Witness: _____