900 West Magnolia Street
Kissimmee, FL 34741

OSCEOLA SURGICAL
ASSOCIATES

407-870-0808 Phone
407-870-9128 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________ SSN# (Optional): ________________

INFORMATION REQUESTED FROM:	REQUESTOR OF INFORMATION
FROM: ❑ Self ❑ Other ____________	**TO:** ❑ Self ❑ Other ____________
Address: ______________________	Address: ______________________
______________________	______________________
Phone #: ______________________	Phone #: ______________________
Fax#: ______________________	Fax#: ______________________

INFORMATION TO BE DISCLOSED *(please specify)*:

Description	Date (s)	Description	Date (s)	Description	Date (s)
❑ Problem List ❑ Progress Notes ❑ History & Physical ❑ Other (please specify) ❑ Lab Reports ❑ Medications		❑ Radiology Reports ❑ Immunization Records ❑ Specialist Reports ❑ OB Reports ❑ All Records ❑ HIV Testing		❑ HIV & AIDS Documentation ❑ Psychiatric Documentation ❑ Alcohol & Drug Abuse Documentation ❑ Other ______________	

PURPOSE OF DISCLOSURE *(please specify)*:

❑ Continuing care with another physician or hospital. ❑ Personal Copy ❑ Other *(please specify)*: ____________

AUTHORIZATION:

I understand that:

1. This authorization will remain in effect for 30 days.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form after I sign it.
8. I understand that the information in my or my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavorial or mental health services, and treatment for alcohol and drug abuse.

Patient/Guardian/
Representative Signature: ______________________________ Date: ____________________

DMS 43274621 (R 12/08)