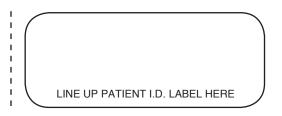


Practice Management 83 W. Columbia St., Orlando, FL 32806 tel 321.841.3064 • fax 321.843.6854



AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

PATIENT AND REQUESTOR INFORMAT	ION:				
Patient Name:		/ Date of Birth///			
Address:		Social Security Number (last 4 digits #)			
Requestor Name:	I.D. Shown	Method of Delivery: ☐ Mail ☐ Electronic			
Email Address: Telephone					
PLEASE SPECIFY IF YOU WANT US TO RELEASE INFORMATION TO, OBTAIN INFORMATION FROM, OR REVIEW INFORMATION					
I hereby allow Arnold Palmer Pediatric Practices to: ☐ Release Information to: Name: Address: Phone Number: Fax Number: (Orlando Health Policy - We only fax to r) ☐ Obtain Information From:	nedical facilities)	Check Applicable Practic ☐ Craniomaxillofacial ☐ Endocrine ☐ Gastroenterology ☐ Genetics ☐ Infectious Diseases ☐ Other: ☐ Records to be Released ☐ Complete Record	□ Neuro □ Neuro □ Ortho □ Pulmo □ Physi	osurgery opsych opedics onology atry	
Facility Name:		☐ Office Notes ☐ Test Results ☐ Other (specify)	☐ Opera	☐ Radiology ☐ Operative Report	
Fax Records to: APH Health Info Management: 321.843.6854 Mail Records to: 83 W. Columbia St., Orlando, FL 32806 □ Allow Review of Medical Records: Name of Reviewer: Relation to Patient:		Purpose of Release: ☐ Insurance ☐ Continued Treatment ☐ Legal Actions ☐ Personal Use ☐ Family and Medical Leave Act/Disability Forms ☐ Other (please specify):			
This authorization will expire on the following date, event or condition: I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunode-ficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.					
May NOT include information related to (please initial): HIV/AIDS Mental Health Drug and/or Alcohol Abuse Genetic Counseling/Testing Information					
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.					
Patient/Legal Representative or Parent/Legal	nature Da	ate	Time		
OFFICIAL USE ONLY:					
Name Number of Pages Copied:		Date: Time		ing Information	
□ I wish to revoke this authorization. Signature:					