PATIENT REQUEST FOR HEALTH INFORMATION

ORTHOPAEDIC SPECIALTIES
A division of Florida Orthopaedic Institute

First Name:	Middle Initial:	Last Name:	Date of Birth:
Street Address:	City:	State:	Zip:

Facility Information

Clinic/Hospital Name:			
Street Address:	City:	State:	Zip:

A $6.50 fee for CD and payable in advance to SHARECARE - TEN pages of documents are free, a small fee over 10.

CHECK INFORMATION NEEDED

☐Office Notes ☐Imaging on CD ($6.50 prepaid) ☐Medications ☐Immunization Records ☐Procedures / Operative Notes ☐Imaging Reports

☐Lab/Test Results/Blood tests ☐Other (specify)_____

Which types of sensitive information do you authorize for release?

☐Genetic / Hereditary Test Results ☐Substance Abuse Information ☐HIV Test Results ☐Sexually Transmitted Disease ☐Behavioral / Mental Health Records

(Optional) What is the primary reason for your request? This may help us respond more completely to your request. _____

What time are you requesting information from? (Specify a range of dates or years like “last 2 years”)
_____through _____

SELECT ONE OPTION FOR DOCUMENT DELIVERY

☐ Mail ☐ Email: _____

Recipient information is required. If you requested a CD, it will be mailed to this address. Please fill out address even if the delivery method is not mail.

Name:	Street Address:	
City:	State:	Zip:
Provide any additional detail or contact information for the recipient below (optional):		

Please print your name and sign below:

Name:	Relationship (if other than patient):
Signature:	Date:

For information regarding the medical records release or other information call (813) 280-4345
Medical release form can be faxed, emailed or sent via USPS a follow: Fax (858) 430-4938 Email: sharecare@floridaortho.com
Mail: 1011 Jeffers St., Clearwater, FL 33756 5.2.2022