

Authorization to Obtain Health Information

Arthrex Medical Center • 1284 Innovation Drive, Suite 100 • Naples, FL 34108

Patient's Full Name:		Date of Birth:	
Patient's Address:	City, State:	ZIP:	

1. I request and authorize Arthrex Medical Center to obtain my health care information from:

Provider:

Send to: Arthrex Medical Center | 1284 Innovation Drive, Suite 100 | Naples, FL 34108 | Fax: (239) 591-2491

2. The health care records I wish Arthrex Medical Center to obtain from the provider named above include:

- | | |
|--|--|
| ☐ Physical report/notes, including EKG if > 40 years of age | ☐ Lab analysis |
| ☐ Pap smear (annual) | ☐ Prostate exam |
| ☐ Mammogram | ☐ EKG |
| ☐ Radiology | ☐ Other: |
| ☐ Colonoscopy | |

3. Date the authorization will expire: Two (2) years from the date signed below.

By signing this Authorization, I understand that:

- This Authorization shall apply to my health information which is protected under the Health Insurance Portability and Accountability Act of 1996, as amended.
- Requests for copies of medical records may be subject to reproduction fees in accordance with federal/state regulations.
- Arthrex Medical Center, as my agent, will be treated by the provider named above in the same manner as I would be treated with respect to my rights regarding the use and disclosure of my protected health information.
- Arthrex Medical Center, as my agent, and their successor agent(s), will be provided with the medical records initialed in no. 2 above regarding any past, present, or future medical condition, including, but not limited to, any and all information relating to the diagnosis and/or treatment of a mental health condition, mental illness, sexually transmitted disease, alcohol and/or drug abuse, or genetic testing.
- Unless otherwise revoked, this Authorization will expire on the date in no. 3 above.
- I have the right to revoke this Authorization at any time. Revocation must be made in writing and presented or mailed to Arthrex Medical Center at 1284 Innovation Drive, Suite 100, Naples, FL 34108. Revocation will not apply to information that has already been obtained in response to this Authorization.
- I understand that Arthrex may transmit my PHI to and from my other health care providers in an electronic format using a secure, privacy-protected computer network that complies with state and federal privacy laws.

Print Patient Name:	Date:
Patient or Authorized Representative Signature	Relationship to Patient (if applicable):

This document is confidential and proprietary and intended for internal use only. It may not be reproduced, used or disclosed to others without the written consent of the Arthrex Medical Center. This Authorization will expire 2 years from the date indicated above.

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