

Authorization to Disclose 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 that my protected health information (PHI) from Arthrex Medical Center be disclosed to:

- ☐ Any physician(s) that Arthrex Medical Center refers me to now or in the future.
- ☐ Only the physician(s) named here:
- ☐ I do not want my PHI disclosed to any referring physician.

2. I authorize the following PHI to be released from my medical records:

- ☐ Entire medical records, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Medical records from (insert date): to (insert date):
- ☐ Alcohol/drug treatment
- ☐ Mental health treatment
- ☐ HIV-related treatment
- ☐ Genetic testing
- ☐ Other:

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

By signing this Authorization, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- 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 disclosed in response to this Authorization.
- Unless otherwise revoked, this Authorization will expire on the date in no. 3 above.
- I understand that signing this Authorization is voluntary. My treatment, payment, enrollment or eligibility for benefits will not be conditioned upon whether I sign this Authorization.
- Information disclosed under this Authorization might be (redisclosed) by the recipient and this redisclosure may no longer be protected by federal or state law.
- 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 that complies with state and federal patient privacy laws.

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

Authorization to Disclose 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 that my protected health information (PHI) from Arthrex Medical Center be disclosed to:

- ☐ Any physician(s) that Arthrex Medical Center refers me to now or in the future.
- ☐ Only the physician(s) named here:
- ☐ I do not want my PHI disclosed to any referring physician.

2. I authorize the following PHI to be released from my medical records:

- ☐ Entire medical records, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Medical records from (insert date): to (insert date):
- ☐ Alcohol/drug treatment
- ☐ Mental health treatment
- ☐ HIV-related treatment
- ☐ Genetic testing
- ☐ Other:

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

By signing this Authorization, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- 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 disclosed in response to this Authorization.
- Unless otherwise revoked, this Authorization will expire on the date in no. 3 above.
- I understand that signing this Authorization is voluntary. My treatment, payment, enrollment or eligibility for benefits will not be conditioned upon whether I sign this Authorization.
- Information disclosed under this Authorization might be (redisclosed) by the recipient and this redisclosure may no longer be protected by federal or state law.
- 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 that complies with state and federal patient privacy laws.

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