BECKER ORTHOPEDICS
Advanced skills and experience for the results you deserve
3501 Health Center Boulevard, Suite 2230
Bonita Springs, Florida 34135
Phone: 239-949-3045 Fax: 239-949-3015

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT	Patient name (print)			Date of Birth
	Street Address			
	City	State	Zip	Phone #
Health Information Released FROM: (***Who*** has the information you want released?)	Name **Becker Orthopedics**			
	Street Address **3501 Health Center Blvd., Suite 2230**			
	City **Bonita Springs**	State **FL**	Zip **34135**	Fax # **239-949-3015**
Health Information Released TO: (***Where*** do you want the information sent?)	Name			
	Street Address			
	City	State	Zip	Fax #

Health Information to be Released: (***What*** records do you want released?)	For condition or dates of treatment:_____ ☐ Entire medical record **OR** to only release specific portions of your health information, indicate the categories to be released: ☐ Office notes ☐ MRI reports ☐ Operative reports ☐ Other_____
Purpose of Release: (***Why*** is it needed?)	☐ Personal use ☐ Legal* ☐ Other _____ ☐ Continued care ☐ Insurance* *There may be a charge/fee for copies of records under FL Statute 395.3025.
Authorization/Revocation	By signing this authorization I understand the following: This form expires one year from the dated I sign it unless otherwise indicated here: _____. I am requesting that the health information marked above be released to the person, clinic or organization above. I may revoke this consent at any time in writing to Becker Orthopedics. If I do not sign this form, I will still be treated. Upon release, this health information is no longer protected by Becker Orthopedics and may be released to a third party. A faxed/copy of this authorization is as valid as the original. **Signature** _____**Date:** ____/_____/____ Or legally authorized representatives signature_____ Representative's relationship to patient ☐ Parent ☐ Guardian ☐ Other _____