Access Request Form

Name: _____ Chart #: _____ Date: _____

I hereby authorize Orlando Orthopaedic Center to use or disclose my protected health information as indicated below to:

Name _____

Phone # _____ Fax # _____

Address: _____

City _____State _____ Zip Code _____

E-mail: _____

Information to be released:

Written Records:

____ Office notes Date(s): _____

____ Lab Results Date(s): _____

____ Work Status (DWC25) Date(s): _____

____ Physical Therapy notes Date(s): _____

____ Operative Reports Date(s): _____

____ Diagnostic Imaging Reports (MRI/EMG/Bone Scans, etc) Date(s): _____

____ Other (please specify): _____

Images/Other:

____ X-Ray Date(s): _____

____ MRI Scan Date(s): _____

____ Nuclear Medicine/Bone Scan Date(s): _____

____ CT Scan Date(s): _____

____ Other: _____

Records to be provided via:

☐ Email_____ ☐ Regular Mail ☐ Pick up (specify location) _____

☐ Fax _____ ☐ Other (specify): _____

IMPORTANT NOTICE:

I understand that Orlando Orthopaedic Center is not required to release original medical records or images. All medical records and images are the property of Orlando Orthopaedic Center and are subject to a reproduction fee. The insurance carriers are not financially responsible for the reproduction of medical records/images. My medical treatment, insurance benefits, and payments are not affected by the signing of this form.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the **Privacy Officer for Orlando Orthopaedic Center at 25 West Crystal Lake St #200 Orlando FL, 32806**. I understand that such a revocation is not effective to the extent that Orlando Orthopaedic Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this request may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

I understand it may take 7-10 business days for this request to be processed. I also understand that I am responsible for the cost of reproduction as listed on the following page. _____

Patient's Initials

Orlando Orthopaedic Center
Duplication Fee Schedule

Patient Record Requests

Records (paper, email, etc.)	Commercial Insurance / Other Payor Patients • $1 per page for the first 25 pages • $.25 per page after 25 pages Work Comp Patients • $.50 per page (per Florida law)
Imaging / Surgical Pictures	$10 per CD
Postage	Varies by weight and size

Third-party Record Requests

(I.e. Attorneys, Insurance Companies, etc.)

Records	$ 1 per page $ .50 per page (WC patient's attorney only)
Imaging / Surgical Pictures	$10 per CD
Postage	Varies by weight and size

Reference Sources:
Florida Administrative Code – 64B8-10.003
Florida Rule 69L-7.601