Foot & Ankle Associates of Florida
We care about every step you take.

CONFIDENTIAL
PHI/Release Of Health Information

Patient Name: _____ **Phone No:** _____

DOB: _____ **SSN:** **XXX – XX -** _____

Purpose/Need for information: __Changing Physicians __Personal file __Primary Dr __ 2nd Opinion __ Legal

Documents requested: _____Office Notes (including notes of labs, written x-ray report, test results)
from date:_____ to date:_____

Other: _____

Records fees	**$1.00 per page up to 25, $0.25 per additional page, these are the allowable fees according to FL Statute, courtesy copies of the last 3 visits are provided at no charge.** ***Records released to your Primary Care Dr. or other Dr. for 2nd Opinion – fees waived.***	
CD'S of X Rays	**$10.00 each –digital films available on CD + postage if applicable.** ***Fees for x-rays on CD apply for all 2nd opinion requests.***	**Total Charges: $**

☐ **I will PICK UP my records** ☐ **Mail records to home address on file** ☐ **Fax to # below**

___ RELEASE My Records TO: ____ Personal ____ ***Dr. Office name, PH. and FAX No.***

_____

_____

___ OBTAIN My Records From another Physician's office: ***Please provide Dr. Office name, PH. and FAX No.***

_____

By signing this form, I request/authorize the release of my ***Health Information Records*** *as described. I understand this form remains in effect for 90 days.*

Patient Signature: _____ **Date:** _____

IMPORTANT, in accordance with Health Insurance Portability and Accountability Act of 1996(HIPAA): This request is authorized to include any Patient Health Information (PHI) Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information, 397.053/ 396.112 Drug and/or Alcohol Abuse Information, HIV and AIDS related conditions and/or 397.50(3) records. Fees are according to guidelines established in Florida Statutes 395.301, Rule 64B8-10.003, Florida Administrative Code

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