MIAMI BONE & JOINT INSTITUTE

Date: _____

Medical Records Release

Patient Authorization to use or Disclose Protected Health Information

I, _____ understand that my physician is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health Information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below. **PHOTO ID WILL BE REQUIRED.**

Patient Name (*Print*): _____

SS#/DOB: _____

Phone (*Home*): _____-_____-_____ Phone (*Mobile*): _____-_____-_____

Medical Records are to be released to: _____

☐ By Mail (Address): _____

City:_____ State: _____ Zip Code:_____

☐ Fax (*Number*): _____-_____-_____ **Pages 1-5: No Charge** **X-rays: $10.00**

☐ To be picked up **Pages 5+: $1.00 (*each*)** **Worker's Comp: $0.50**

***Please check the specific record(s) to be released.**

☐ Entire Medical Record ☐ Nerve Conduction Study Result ☐ Therapy Notes ☐ Office Notes

☐ Operative Reports ☐ X-Ray copies ☐ other _____

Office Signature, THI: _____

I authorize THI to disclose my health information as detailed above to the following person(s):

_____

Signature: _____ (*Check if Guardian*)____

Guardian Name (*Print*): _____ (if applicable)

8905 SW 87th Ave. Suite #100
Miami, FL. 33176
Phone: 305-667-8686
Fax: 305-667-8680

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Miami, FL. 33176
Phone: 306-667-8686
Fax: 305-908-2127

11760 Bird Road. Suite 610
Miami, FL 33175
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