AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:____________________ DOB:____________________ SS#: ___________________

I request and authorize the release of healthcare information to Arthrex Medical Center from:

Dr. / Hospital: ____

Release healthcare information of the patient named above to:
Arthrex Medical Center
1284 Creekside Street, Suite 105
Naples, FL 34108
Medical records fax: 239-591-2491

This request and authorization applies to:

☐ Physical report/notes within the last six months (including EKG if >40 years old)

☐ Lab analysis within the last six months
Lab analysis for **males** must include:

- CBC Lipid Panel
- CMP TSH
- HA1c Urinalysis
- PSA (male >40 years old)
- Testosterone

☐ Prostate Exam (male >40 years old)

☐ Colonoscopy Report (>50 years old and every 10 years)

☐ Other: _________________________________

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☐ Lab analysis within the last six months
Lab analysis for **females** must include:

- CBC Lipid Panel
- CMP TSH
- HA1c Urinalysis

☐ Pap Smear (annual)

☐ Colonoscopy Report (>50 years old and every 10 years)

☐ Mammogram (>35 years old)

☐ Other: _________________________________

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This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164. I intend my agent to be dealt with by all my health care providers, as required by HIPAA, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s) named above, without restriction and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse.

Patient Signature: ____ Date Signed: ________________________________