UNOVA HIP&KNEE CENTER

Authorization to Release Protected Health Information

This form collects information that is part of the medical record.

Encounter Number	Name *(First, Middle, Last)*	Birth Date *(MM/DD/YYYY)*

Instructions: If **any** section is incomplete, this form may be invalid.

Release Information From

☐ **UNOVA Health, 539 Rolling Acres Rd Lady Lake, FL 32159**

☐ Other: *Specify facility/individual & address below, including phone/fax if known.*

_____

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Release Information To

☐ **UNOVA Health, 539 Rolling Acres Rd Lady Lake, FL 32159**

Attn:_____ Bldg._____ Rm._____

☐ Other: *Specify facility/individual & address below, including phone/fax if known.*

_____

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Purpose of Release

☐ Treatment/Continued care ☐ Personal ☐ Legal purposes

☐ Application for insurance ☐ Disability determination ☐ Payment of insurance claim

☐ Other

Information To Be Released

(Required - check all that apply)

☐ Clinic notes ☐ Laboratory reports ☐ Radiology reports

☐ History and physical ☐ EKG's ☐ Radiology images

☐ Operative reports ☐ Immunization records ☐ Billing information

☐ Other (specify information to be released in the space below)

Service dates (optional) From To	Verification of identity (Driver's license, ID card, Passport)

- I understand that by federal law, UNOVA Health may not use or disclose protected health information (PHI) without authorization except as provided in UNOVA Health Notice of Privacy Practice. By signing this Authorization, I am giving permission for the use or disclosure of the PHI described above. I hereby release UNOVA Health directors, officers, and employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this Authorization by faxing (352) 775-6352 or mailing the request to UNOVA Health P.O. Box 489 Lady Lake, FL 32158. The revocation will not apply to any information already released as a result of this Authorization.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by federal health information privacy laws and could be re-disclosed by the person or agency that receives it.
- I understand that I may be charged a fee of up to $1.00 per page (plus tax, postage, and handling) for every page printed and that this fee is within the limits allowed by Florida Statute 395.3025(1).

Signature *(Required)*	**Date of Signature** *(Required)(MM/DD/YYYY)*

Printed Name of Person Signing (if Not Patient)

Mailing Address of Patient

City	State	ZIP Code	Phone

This Authorization expires automatically one (1) year from the date signed, unless a different expiration date is written here: ____/____/____