CENTRAL FLORIDA
BONE & JOINT INSTITUTE

Authorization For The Release of Medical Records

I authorize: Central Florida Bone & Joint Institute

1639 N. Volusia Ave. Suite B, Orange City, FL 32763

Phone: (386) 775-2012 fax: (386) 775-2013

To Release or Request records :

Name of Organization	Phone Number
Street Address	Fax Number
City, State, Zip Code	E-mail

Records to be Released :

- ☐ Entire Record
- ☐ Office Notes
- ☐ Operative Reports
- ☐ Imaging Reports (MRI, CT, Ultrasound, Xray etc)
- ☐ Lab Reports
- ☐ Physical Therapy
- ☐ Itemized Bill
- ☐ EMG report

Treating Physician	Body Part	Dates of Services

Patient Information:

Name	Date of Birth
Address	Phone Number
Patient Signature	Date

*I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire one year from the date of signature, unless I revoke the authorization prior to that time.