SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
5060 S Florida Avenue • Lakeland, Florida 33813
Phone: (863) 688-3030 • Fax: (863) 688-4430
www.SpineInstituteFL.com

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Phone Number:_____

D.O.B_____ Last 4 of your SSN:_____

Address: _____

City: _____State: _____Zip: _____

I hereby AUTHORIZE the following to disclose my Individual Protected health Information and Medical Records:

Person/Organization Name: _____
Address: _____
City: _____ State: _____Zip: _____
Fax Number: _____ Phone Number: _____

SENDER

I CONSENT to the release and disclosure of my personal health information and Medical Records to:

Name (Individual or Organization): _____
Address: _____
City: _____ State: _____Zip: _____
Fax Number: _____ Phone Number:_____

RECIPIENT

The type of information to be used or disclosed is as follows (check appropriate boxes and include other information where indicated).

- ☐ Initial Evaluation
- ☐ Operative Reports
- ☐ Progress/Office Notes
- ☐ Work Status
- ☐ Radiology Films/CD and/or Reports
- ☐ Clinical Psychology and Mental Health Records
- ☐ Drug/Alcohol Related Records
- ☐ Communicable Disease (Including HIV, AIDS, and STDs)
- ☐ Addiction and Substance Use Disorder Treatment Records
- ☐ Laboratory and Diagnostic tests
- ☐ Billing Data

☐ Complete Health Record Including: Initial Evaluation, Operative Reports, Progress/Office Notes, Work Status, Radiology Reports and/or Radiology Films/CD, Clinical Psychology and Mental Records, Drug/Alcohol Related Records, Communicable Disease (Including HIV, AIDS, and STDs), Addiction and Substance Use Disorder Treatment Records, Laboratory and Diagnostic tests, Billing Data

____Other_____

____**ALL MEDICAL RECORDS and OPERATIVE RECORDS pertaining to Patients Prior SPINE SURGERY DURING THE FOLLOWING DATE RANGES/DATE:_____. To include Spinal Implant Information and Spinal Implant Sheets/Stickers; Operative Reports for ALL Spine Surgeries during the period of time listed**

☐ Call When records are ready for pick up – Phone #_____

☐ **Please Urgently FAX Records to (863) 688-4430 or**_____

SPINE INSTITUTE
OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

Chukwuka C. Okafor, MD, MBA, CIME
5060 S Florida Avenue • Lakeland, Florida 33813
Phone: (863) 668-3030 • Fax: (863) 668-4430
www.SpineInstituteFL.com

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (Continued)

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management department in writing, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. I understand that my revocation does not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
2. I understand that I am signing this form voluntarily and I am signing this under my own free will. Spine Institute of Central Florida will not condition my treatment, payment enrollment in health plans or my eligibility benefits by signing this form.
3. I further agree to pay charges to provide the information requested per Florida Statute 395.3025 or Florida Administrative code 64B8-10.003.

For the Recipient:

4. I understand that any substance use disorder and addiction treatment records are protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Patient Signature: _____ Date:_____
Patient or Authorized Person ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Personal Representative ☐ Power of Attorney

☐ Photo ID verified

Witness: _____ Date:_____