Optimotion Orthopaedics

5979 Vineland Rd. Suite 101 Orlando, FL 32819
Phone: 407-355-3120 / Fax: 407-355-3119

Authorization for Exchange of Confidential Information

I, _____, hereby authorize Optimotion Orthopaedics to (check one) ☐ **release /** ☐ **obtain** all medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis and information ☐ **to /** ☐ **from:**

_____
(Name of Individual, Healthcare Provider or Agency)

_____
(Street) (City) (State)
(Zip)

For the purpose of: ☐ Continued Medical Care ☐ Second Opinion ☐ Insurance ☐ Attorney ☐ Personal_
(Specify purpose of disclosure of records)

For Release Only: Are you transferring your total care ☐ **to/** ☐ **from** Optimotion Orthopaedics ☐ **to/** ☐ **from** the provider mentioned above: ☐ **Yes** ☐ **No**

I understand this consent is revocable upon written notice to Optimotion Orthopaedics, Steve Nguyen, M.D., or Nam Dinh, M.D., except to the extent that the action by Optimotion Orthopaedics has already been taken on by this authorization. This authorization shall remain in force for a reasonable time to accomplish the purpose for which it is given, or will expire (in six (6) months).

I hereby release Optimotion Orthopaedics, and its employees, agents, officers and affiliates, from any and all legal liability, responsibility, claim and damage that may arise from the release of information as requested.

Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR, part 2) prohibits making any further disclosure of the information without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Notice to Requesting Party: There will be cost associated with this request. Your signature on this form indicates your knowledge of the fee. The medical records will be provided after the fee is paid.

_____ X_____
Date Signature of Patient

_____ X_____
Patient Date of Birth Signature of Parent, Legal Guardian or Authorized Representative

Form of ID verified:

Specific Records Released: ☐ Driver's License ☐ ID card ☐ Passport ☐ Other: _____
☐ Mail ☐ Faxed ☐ Patient Pick-Up

Date: _____ By: _____