□2318 Greenbranch Drive
Building 2, Suite #101-102
Wesley Chapel, FL 33544
Fax # (813) 972-8866

Ph. # (813) 866-4426
advancedsurgery@yahoo.com

□4600 N. Habana Ave
Suite 22
Tampa, FL 33614
Fax # (813) 514-1350

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ____________________________________ Phone: ______________________ DOB: _______________

Address: ____City:__________________State:_________ Zip: _________

I request and authorize Advanced Hand and Plastic Surgery Center, LLC to Release healthcare information to:

Name: ____

Address: ____

City: __________________________ State: __________ Zip: ____________

Phone: _______________________ Fax: ____________________________

□Release to Patient: □Fax □Mail □Pick-up (Habana or Wesley Chapel)

Information to be released:

□ Office Notes: Date(s) of Service: ______________________________or □ All Office Visit Notes

□Diagnostics: Type of Report(s):_________________________Date(s) of Service: ____________________________

□Lab: Date(s) of Service: ______________________________

□Other (Please specify):___________________________ Date(s) of Service: _______________________________

Purpose of Release:

□Legal □Insurance □Personal Use □Continued Medical Care □Other (Specify) ______________

THIS AUTHORIZATION SHALL EXPIRE NINETY DAYS FROM THE DATE OF SIGNATURE

Important: By signing below, patient understands that this Authorization for Release of Medical Records ("Authorization") shall only include medical records dated prior to and including the date of this Authorization. Patient understands that this Authorization shall only include medical records originated through Advanced Hand and Plastic Surgery Center and /or its affiliates (the "Practice") unless otherwise specifically requested. Patient further understand that this Authorization is voluntary and patient may refuse to sign. If patient refuses to sign, patient's refusal will not affect patient's ability to obtain treatment from the Practice. Patient understands that this Authorization may be revoked at any time by notifying the Practice's Privacy Officer at Advanced Hand and Plastic Surgery Center, LLC, 2318 Greenbranch Drive Bldg. 2 Suite 101-102, Wesley Chapel, Florida 33544. However, revocation shall not be valid to the extent the Practice has taken action in reliance on this authorization or to the extent this Authorization is executed as a condition for obtaining insurance coverage. Patient understands that the Practice shall not condition treatment, payment and enrollment in a health plan or eligibility for benefits (if applicable) on whether patient provides Authorization for the requested use or disclosure.

____ ___________________________________

Patient/ Authorized Representative Signature Date