

**AUTHORIZATION - RELEASE OF WRIST AND HAND CENTER MEDICAL RECORDS**

Patient: I, \_\_\_\_\_

DOB: \_\_\_\_\_

Give: Wrist and Hand Center, PA - John M. Rayhack, MD  
Tampa, FL 33613

my authorization to release confidential information regarding my medical records and status to:

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

The following types of information are specifically authorized for release via US Postal Service Certified Mail:

- \_\_\_\_\_ Typed Progress/Office Notes
- \_\_\_\_\_ Outside NCS/EMG Results
- \_\_\_\_\_ CD of X-rays in digital archives
- \_\_\_\_\_ Laboratory results
- \_\_\_\_\_ Operative Reports
- \_\_\_\_\_ Sensitive Protected Health Information \*\*\*\*

\*\*\* ( additional action is necessary by the patient prior to release of protected health information)

By signing below, I specifically acknowledge delivery of my records via certified mail and accept the risks associated with delivery. I understand that the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule. I hold Dr. Rayhack harmless for any unauthorized access or disclosure occurring during or after the transmission. I have the right to revoke my authorization at any time in writing; however, a revocation will not affect action already taken in reliance on the authorization form. I further acknowledge that fees for copying and providing medical records will be charged in accordance with applicable law, the HIPAA Privacy Rule, and Florida Statutes 64B8-10.003. As a courtesy to our patients, the cost for the records retrieval, printing, x-ray retrieval, scanning, CD burning, and mailing by certified mail to individual patients or their designated physicians has been capped at \$20.00.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_