Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R.Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Fellowship Trained in Surgery of the Hand

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name: ____________________ SS# ____-__-____ Birth Date ___/___/_____

Authorization

1. I, __________________________________, hereby authorize
2. Name of person or organization: ____

   Street Address : ____

   City, state, zip : _______________________________________ Telephone : (   ) ___________
3. A. To release and/or discuss the following information

   Complete Record   Outpatient Care   Inpatient Care

   X-Ray Results   Laboratory Results   Treatment Plan Update

   Other __________________________

   If my record contains the following information, it is also released if *CIRCLED* below:

   Substance Abuse   Mental Health Treatment   HIV Testing or Treatment

4. To _______________________ of   Volusia Hand Surgery Clinic, PA
   3635 South Clyde Morris Blvd Suite 900
   Port Orange, FL 32129

   This information release is at my request for the purpose of legal assistance.

5. Signature :

   I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

   I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

   This authorization expires __________ 6 months _________ one year from today's date, or upon the following specific event: ____.

   I authorize the use of a copy of this form for the disclosure of the information described above.

Signed ____________________________ Relationship _________________________ Date: ____/____/____

Sent by initials _____

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

211 South Volusia Ave
Orange City, FL 32763
(386) 218-4920

FAX:(386)788-0679