RELEASE OF PATIENT RECORDS AUTHORIZATION

DYNAMIC CARE, INC. HIPAA

I hereby authorize _____ (name of practice) to release a copy of my patient records, x-rays or other diagnostic containing protected health information to Dynamic Care Inc. This authorization is given pursuant to Florida Statute 456057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representation.

PATIENT NAME: _____

PATIENT DOB: _____

DATE OF ACCIDENT: _____
(if applicable)
LAST FOUR DIGITS OF SSN: _____

Specific description of information to be disclosed:

( ) MEDICAL NOTES
( ) X-RAY / MRI / CT (REPORTS ONLY) ***MAY BE FAXED TO 407-260-1619***
( ) X-RAYS **(Films or CDs may be sent or delivered to the address below)**
( ) MRI / CT **(Films or CDs may be sent or delivered to the address below)**
( ) INSURANCE INFORMATION
( ) OTHER _____

_____
Patient's or Patient's Legal Representative's Signature

_____
Date Signed

Unless revoked by me in writing, this authorization shall expire in 12 months from the date signed.

Dynamic Care Inc. **609 Maitland Ave, Suite 4** **Phone 407-767-2000**
Altamonte Springs, FL 32701 **Fax 407-260-1619**