Authorization To Release Patient Health Information

BACTES Imaging Solutions has been contracted by C.O.S.S.A. to fulfill all medical record requests
For questions or inquiries, contact BACTES Customer Care 1-877-548-4069

Children's Orthopaedic & Scoliosis Surgery Associates
625 6th Avenue South · Suite 450 · St. Petersburg, FL 33701
Phone (727) 898-2663 · Fax (727) 568-6836
3440 West Dr. Martin Luther King Jr Blvd. Suite 200· Tampa, FL 33607
Phone (813) 879-2663 · Fax (813) 872-0286

Patient Full Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I hereby authorize the release and disclosure of the specific health information listed below to:

Name (Individual or Organization):_____

Send by: ☐ **Fax #:**_____ ☐ **Email:** _____

☐ **Mail to:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____

For the release of:

Office Notes ☐ Disc of X-Rays ☐ Operative Reports ☐

Date Copy of C.O.S.S.A. records are needed:_____
Note: Please allow 5-7 business days for medical records requests to process. If you are requesting x-rays or records for legal files, there may be a charge. Please call BACTES Customer Care for more details.

Reason for Records:

Second Opinion ☐ Bracing ☐ Legal ☐ Insurance ☐ Personal ☐ Other ☐

Please Specify: _____

Patient's Signature_____ **Date**_____
(Required for all patients 18 years and older.)

Parent/Guardian Signature_____**Date**_____
(Required for all patients under the age of 18 unless otherwise allowed by law.)

- *This consent is subject to revocation at any time, in writing, but may not be revoked to include the release allowed by this document. Unless otherwise specified, this authorization will be valid for a period of six (6) months following the date of signature.*
- *I understand that my treatment or continued treatment by COSSA and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that I may inspect or copy the information that is used or disclosed.*