Miki & Alfonso Hand & Upper Extremity Center

9035 Sunset Drive Suite 203

Miami FL, 33173

Office: (305) 308-0210 Fax: (305) 273-2176

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Please allow a minimum of 5 business days to process your request.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records. I have read and understand the following statements:

1. I understand that upon release of my records I will need to present a valid driver's license.

2. I understand that there is a price of $1 per page for the first 25 pages, and 25 cents for each subsequent page.

Date: _____

Name (Requesting Records) : _____

Phone Number: _____ **Fax Number:** _____

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

The purpose of this request: ____ **Personal Request** ___ **Treatment (Continued Care)**

Patient Signature: _____

Printed Patient Name:_____

For Office Use Only