Orthopedic Surgery

Christine Kohler Ekstrand, M.D.
Delray Medical Staff
West Boca Medical Center Staff

5258 Linton Blvd.
Suite 304
Delray Beach, FL 33484
(954) 251-6051 Fax (954) 653-7207
EkstrandOrtho@gmail.com

Medical Release Form

Date: _____, 20____

I **I. THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

I **II. AUTHORIZATION**. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.
Hereinafter known as the "Medical Records."

I **III. DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (____) ____-_____ Fax: (____) ____-_____
E-Mail: _____

Signature of Patient: _____ Date: _____
Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)
The patient is unable to sign due to: (check one)
☐- **Being a Minor**. Patient is ____ years old and considered a minor under state law.☐- **Being Incapacitated**. Patient is incapacitated due to: _____.☐- **Other**: _____.
Signature of Representative: _____ Date: _____
Print Name: _____
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____