James J. Guerra, MD, FACS
Board Certified & Fellowship Trained Orthopaedic Surgeon
Specializing in Sports Medicine & Arthroscopic Surgery

COLLIER SPORTS MEDICINE AND ORTHOPAEDIC CENTER

FELLOW OF:
American Academy of Orthopaedic Surgeons (AAOS)
American Orthopaedic Society for Sports Medicine (AOSSM)
Arthroscopy Association of North America (AANA)
International Society of Arthroscopy, Knee Surgery, and Orthopaedic Sports Medicine (ISAKOS)
American College of Surgeons (FACS)

MEDICAL AUTHORIZATION FOR USE OR DICLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: ____

Date of Birth: ________________ Social Security #: ______________________

Address: ____

I, the undersigned patient or legal representative, hereby authorizes:

James J. Guerra, MD, FACS
1706 Medical Boulevard, Suite 201
Naples, Florida 34110
Phone: (239)593-3500 Fax: (239)593-9163

to disclose the following health information:

- ☐ Progress Notes
- ☐ X-RAY/MRI Films and/or Reports
- ☐ Labs
- ☐ Operative Report
- ☐ Other: ________________

As required by the Health Insurance Portability and Accountability Act (**HIPAA**) and Florida Law, the undersigned authorizes the release of all medical records to:

____
(Name and Address)

____
(Phone Number and Fax Number)

I understand that I may revoke this authorization at any time by notifying you in writing. This medical authorization will automatically expire in one (1) year from the date of signing, unless revoked by myself or my authorized representative prior to that time.

_________________________________ _________________________
(Patient/Authorized Representative's Signature) (Date)

_________________________________ _________________________
(Print Patient's name/authorized Representative Name) (Witness)

HEAD TEAM PHYSICIAN
FLORIDA GULF COAST UNIVERSITY