

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



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 DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

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

\_\_\_\_\_  
(Name and Address)

\_\_\_\_\_  
(Phone Number and Fax Number)

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:

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

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

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