

Date: ___/___/___



Account # _____

Release of Information Department
4601 Park Road, Suite 250
Charlotte, NC 28209
704-323-3580 (Phone) / 704-323-3584 (Fax)

Authorization for Release of Health Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below.

Patient Name: _____
(Last) (First) (Middle / Maiden)

Patient Address: _____
(Street Address) (City, State) (Zip code)

Social Security #: _____ - _____ - _____ Date of Birth: ___/___/___

Telephone #: ___/___/___ Cell/Work #: ___/___/___

Please check the specific information to be released (used or disclosed) and the related date(s) of service:

Date from: _____ Date to: _____ Pertaining to: _____

Clinical Notes Test Results Operative Note Medication List Work Status Form Itemized Bill PT Notes

Copy Fees: Medical record copies will be provided to you by our contract copy service, **Archivus. LLC** at a minimum fee of \$15.00 per request + postage (fee is based on number of pages) and maximum of \$50.00. North Carolina Statutes allow for copy charges - regardless of reason - when terminating care with one practice and moving to another.

Please note that originals will not be released.

Purpose of Disclosure: Medical Review Legal Review Insurance Review Personal Use Other _____

I authorize OrthoCarolina to release the requested health information to:

Name/Organization: _____
(i.e. Self / Healthcare Provider/ Insurance)

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: ___/___/___ Fax #: ___/___/___

Note: Faxing applies only to healthcare providers

Please check your preferred method for releasing the requested information:

I will pick-up Fax to the number provided above (Only for release to healthcare providers)

I will have someone pick-up for me Mail to the address provided above

Individual's Name: _____ Relationship: Spouse Parent Child Other _____

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the OrthoCarolina Privacy Office and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by OrthoCarolina before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. *I understand that the information in my medical record may include information relating to treatment for drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and/or human immunodeficiency virus (HIV). This authorization will expire in 90 days, unless otherwise noted.

Signature: _____ Date: _____
(Patient or Authorized Representative – Relationship: Spouse Parent Other: _____)

*Please note: the information following the asterisk above applies to minors as well as emancipated minors.

Signature of Minor / Emancipated Minor: _____

Please allow 7-10 business days to process your request.