Health Information Management Services/Release of Information Department

Mail form to: 4601 Park Road, Suite 250, Charlotte, NC 28209

Email Request to: OrthoCarolinaMedRec@orthocarolina.com Phone 704-323-2049 / Fax 704-323-3806

AUTHORIZATION FOR ACCESS/USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the access, use, or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations *and further charges may apply.*

Patient Name: _____Date of Birth: _____MRN: _____

Address: _____City: _____State: _____Zip: _____

Telephone: _____ Cell/Work: _____

Information to be Released:

☐ Medical record(s) for the dates from _____ to _____

Check all that apply:

☐ Office Notes ☐ Operative Report ☐ Discharge Summary ☐ Physical Therapy ☐ Laboratory Results

☐ MRI Reports ☐ CT Reports ☐ Itemized Statement ☐ Other (please specify) _____

☐ Radiology Image(s) for the dates from _____to_____

Check all that apply:

☐X-rays ☐ MRI ☐ CT ☐ Other (please specify body part) _____

This information is to be disclosed to the following individual or entity (**MUST BE COMPLETED):**

Name: _____Relationship: _____

Address: _____E-Mail Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax Number: _____

Purpose of Release: ☐ Medical/Patient Care ☐ Legal Review ☐Insurance ☐Personal Use ☐ Other_____

Medical record copy fees are determined by both the nature/purpose of your request and the format/method of delivery.
Please Note* If requesting both Medical Records and Images there is a separate fee for each request.

Please check your preferred format/method for receipt/release of the information:

- ☐ Upload medical records to the Patient Portal
- ☐ Email medical records to the email address provided.
- ☐ Email Radiology images to the email address provided.
- ☐ Fax medical records to the number provided.
- ☐ Mail paper records to address provided.
- ☐ Mail CD of Radiology images to the address provided.
- ☐ Pick Up records at _____. Call (_____)_____-_____ when ready.

*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). I understand that I may revoke this authorization at any time by notifying Orth Carolina in writing, but if I do it won't have any effect on any actions Orth Carolina took before it received the revocation. I understand that Orth Carolina cannot make me sign this authorization as a condition to receive treatment from Orth Carolina except:

(i) when Orth Carolina provides me with research-related treatment; or

(ii) when Orth Carolina provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Orth Carolina, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that by signing below, I am agreeing to, and certifying my understanding of all statements above. **This authorization will expire one year from date of signature. (*Form MUST be completed before signing*)**

_____ _____

Signature of Patient Name:

_____ _____

Relationship/Authority if signature is not that of the patient. Date:

Office Use Only (To be completed by OC staff if request is fulfilled in the clinic/office):

Completed in office by: _____ Location: _____ Date: _____