

Date: \_\_\_/\_\_\_/\_\_\_



Account # \_\_\_\_\_

**Health Information Services Department**  
4601 Park Road, Suite 300  
Charlotte, NC 28209  
704-323-2049 (Phone) / 704-323-3941(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)

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 at a *minimum* fee of \$10.00 per request + postage.  
*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.**