

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



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

**Radiology Department**  
4601 Park Road  
Suite 300 Charlotte, NC, 28209  
704-323-3858 (Phone) / 704-323-3806 (Fax)  
**Authorization for Release of Radiographic Images**

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:

- Radiology Films Date(s): \_\_\_\_\_ Pertaining to: \_\_\_\_\_
- MRI Date(s): \_\_\_\_\_ Pertaining to: \_\_\_\_\_

**Copy Fees**

- Images will be provided to you on CD at the cost of \$5.00
- Worker's Comp Patients: No charge to the patient for MRI or X-Ray copies

Purpose of Disclosure:  Medical Review  Legal Review  Insurance Review  Personal Use  Other \_\_\_\_\_

*I authorize OrthoCarolina to release the requested copies to:*

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_/\_\_\_/\_\_\_ Fax #: \_\_\_/\_\_\_/\_\_\_

Please check your preferred method for releasing the requested information:

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

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. This authorization will expire in 90 days, unless otherwise noted.

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

**OrthoCarolina Use Only**

Please check Payment Method:  Patient will pay upon pick-up  Paid by Credit Card  Paid by Check

**Please allow 5-7 business days to process your request.**