NC Orthopaedic Clinic
3609 Southwest Durham Dr, Durham, NC 27707
Phone- 919-403-5140, Fax- 919-477-1929
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____

(Print patient's full name) Birth date (Mo/Day/Yr)

_____ _____

(Street address) social security number

_____ _____

(City, state, zip code) Phone (Home)

_____

Email address

At the request of the individual, I _____, do hereby authorize _____ to release:

(patient's name) **(name of facility)**

_____PROGRESS NOTES _____PATHOLOGY REPORTS _____ ALL RECORDS
_____OTHER DOCTORS NOTES _____LABORATORY REPORTS _____OTHER_____
_____OB/GYN NOTES _____RADIOLOGY REPORTS
_____HOSPITAL NOTES _____ECG/EEG/CARDIC CATH _____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
NAME (Physician, hospital, agency, etc)

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL

OTHER (SPECIFY)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Date**

Reason for transferring: _____

Please provide current telephone number in the event we need to contact you: _____-

NOTE: <u>THERE WILL BE A CHARGE FOR RECORD IN ACCORDANCE WITH THE $.75 (PER PAGE 1 TO 26 PG) ADDITIONAL $.50 PER PAGE (FROM PAGE 26 TO 100) ADDITIONAL $.25 PER PAGE (FROM PAGE 101 & UP) + ACTUAL POSTAGE. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.</u>

Entire_____ LAB_____ mammogram_____ _____
IMM_____ EKG_____ number of pages_____ HEALTHPORT ROI SPECIALIST Date