Release of Information Department
4601 Park Road, Suite 250, Charlotte, NC 28209 – Phone 704-323-2049 / Fax 704-323-3941
OrthoCarolinaMedRec@orthocarolina.com

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the 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.

COPY FEES TO OBTAIN RECORDS: Medical record copies will be provided to you for a fee as and where allowed under HIPAA regulations.

Patient Name: _____Date of Birth: _____MRN:_____

Address: _____

Telephone: _____ Cell/Work: _____

Covering the period(s) of health care: From _____to _____ Pertaining to:_____

Purpose of Disclosure: ☐ Medical Review ☐ Legal Review ☐Insurance Review ☐Personal Use ☐ Other_____

Information to be Disclosed:

☐ Complete health record(s), including all radiology images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all radiology images
☐ All radiology images only

OR Select from the following (check as many as apply):

☐ Progress Notes ☐ Operative Report ☐ Discharge Summary ☐ Test Results ☐ Laboratory Tests
☐ Consultation Reports ☐ Physical Therapy ☐ X-Ray Reports ☐ MRI Reports ☐ CT Reports
☐ Itemized Statement ☐ Photographs ☐ Other (please specify) _____

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:_____

Please allow 5-7 business days for your request to be completed.

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

- ☐ Faxed to the number provided ☐ E-mailed to the address provided
- ☐ I will pick up my records at 4601 Park Road, Suite 250, Charlotte, NC 28209 ☐ paper copies ☐ CD
- ☐ I need to make other arrangements for picking up medical records ☐ paper copies ☐ CD
- ☐ Paper copies mailed to the address provided ☐ CD mailed to the address provided

Please note: We will contact you for payment if required, and/or to coordinate a designated date & time to pick up records.

*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 OrthoCarolina in writing, but if I do it won't have any effect on any actions OrthoCarolina took before it received the revocation.

I understand that OrthoCarolina cannot make me sign this authorization as a condition to receive treatment from OrthoCarolina except:

(i) when OrthoCarolina provides me with research-related treatment; or
(ii) when OrthoCarolina provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

OrthoCarolina, 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 Date

_____ _____
Print Name Relationship of Representative to Patient

Please describe the representative's authority to act on behalf of the patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION