CAROLINA ORTHOPEDICS
SPORTS MEDICINE & PHYSICAL THERAPY

Authorization to Release Health Information

Patient Information

Name of Patient:_____ Date of Birth:_____

Mailing Address: _____

City, State, Zip: _____ Phone: _____

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

Patient Name or Legal Guardian

- ☐ Entire Record
- ☐ Financial Records
- ☐ Diagnostic Studies: _____
- ☐ Op Report
- ☐ On Site Review By Patient
- ☐ Date(s) Of Service: _____
- ☐ Office Visit Note: _____
- ☐ Other:_____

From: Name of Facility or Person: _____ Phone/Fax #:_____

Entity or Person who will receive the information

Name:_____

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Fax:_____

Purpose of Disclosure: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid until revoked in writing by the patient. I understand that I may cancel this request with written notification but that it will not affect any information release prior to notification of cancellation. I understand that the information used or disclosed my 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 authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
NOTE: There will be a charge for a personal copy or the permanent transfer of your reports. Healthport has been contracted to provide this service and will invoice you directly.

_____ _____

Signature of Patient or Guardian/Patient Representative Date

_____

Relationship to Patient if Guardian/Patient Representative

_____

For Office Use Only
ID verified by Photo ID: _____ SS Card: _____ Driver's License: _____ Other: _____