RALEIGH ORTHOPAEDIC CLINIC
FAX: (919) 863-6930
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
NOTE: THERE WILL BE A CHARGE OF $10.00 FOR PERSONAL RECORDS

_____	_____/_____/_____
Patient Full Name	Birth date (Month/Day/Year)
_____	___-___-___
Street Address	Social Security Number
_____	___-___-___
City, State, Zip Code	Daytime Telephone Number

At the request of the individual, I _____ do herby authorize
(patient's name)

Raleigh Orthopaedic Clinic to release:

___ Discharge Summary	___ Pathology	___ Emergency
___ Hist. & Physical	___ Lab Report	___ Other _____
___ Progress Notes	___ X-ray Rep.	_____
___ Operative Notes	___ ECG/EEG/Card	_____

___I do ___ I do NOT authorize release of information related to AIDS or HIV, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
NAME OF COMPANY, AGENCY, OR FACILITY
_____
STREET ADDRESS
_____
CITY, STATE, ZIP CODE

PURPOSE OF DISCLOSURE:

___ Referral to Specialist	___ Insurance	___ Workers Comp
___ Change of Dr.	___ Legal Investig.	___ Disability

___ Personal Use
Personal Use Format: ☐Paper Copy ☐Thumb Drive
___ Continuation of care
___ Other (Specialty): _____

I hereby authorize disclosure of the health information for the above 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 patient or guardian (Or personal rep. of patient's estate)	Date