Release of Information Department

Mail form to: 4601 Park Road, Suite 250, Charlotte, NC 28209

Email Request to : OrthoCarolinaMedRec@orthocarolina.com or Upload to Patient Portal

Phone 704-323-2049 / Fax 704-323-3806

AUTHORIZATION FOR ACCESS/USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the access, 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 *and further charges may apply.*

Patient Name: ___________________________________Date of Birth: _______________________MRN:________________

Address: _____________________________________City:________________State:_______________Zip:________________

Telephone: ____________________________________ Cell/Work: ____

Information to be Released:

☐ Medical record(s) for the dates from _________________________ to _________________________

Check all that apply:

☐ Office Notes ☐ Operative Report ☐ Discharge Summary ☐ Physical Therapy ☐ Laboratory Results

☐ MRI Reports ☐ CT Reports ☐ Itemized Statement ☐ Other (please specify) ______________________

☐ Radiology Images (can only be provided on a CD) for the dates from ______________________to_______________________

Check all that apply:

☐X-rays ☐ MRI ☐ CT ☐ Other (please specify body part) ___________________________________

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:____

Purpose of Release: ☐ Medical/Patient Care ☐ Legal Review ☐Insurance ☐Personal Use ☐ Other_______________

Please allow 14 business days for your request to be processed.

Medical record copy fees are determined by both the nature/purpose of your request and the format/method of delivery.

Please Note* If requesting both Medical Records and CD of Images there is a separate fee for each request.

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

- ☐ Upload records to the Patient Portal
- ☐ Email records to the address provided
- ☐ Fax records to the number provided
- ☐ Mail paper records to address provided
- ☐ Mail CD of records to the address provided
- ☐ Mail CD of images to the address provided
- ☐ Pick Up records at _________________________________. Call (______)_________-______________ when ready.

*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

Revised 12/2020