CAROLINA ORTHOPAEDICS

P.O. Box 4746 Pawleys Island, SC 29585 Phone: 843-294-1941 Fax: 843-299-1015

Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of:

Patient Name: _____

Date of birth: _____

Street Address: _____

City, State, Zip: _____

Telephone: (_____) _____

Email address: _____

Although Carolina Orthopaedics will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From:

_____

_____

_____

_____

Release Information To:

_____

_____

_____

_____

Purpose of Release (check reason):

- o Request of individual / personal
- o Insurance
- o Doctor Requesting
- o Disability
- o Workers Compensation
- o Legal purpose including discussions & proceedings
- o Other:_____

Records to be release (check all that may apply):

- o Office Visit Notes
- o Laboratory Reports
- o X-Ray - Reports
- o X-Ray Burnt on Disk
- o MRI – Reports or Films (Please circle)
- o Billing Information
- o Notes during specific time frame: ____/____/____ to ____/____/____
- o Other_____

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.
- Images burnt on disk may or may not be compatible to your operating system.

This permission expires 90 days after the date of my signature unless another date or event is written here:_____

Signature:_____ **Print name:**_____

Date/Time:_____ **Relationship to patient:**_____

OFFICE USE ONLY: Records sent/ Picked up: ____/____/____ Given By:_____(Employee Signature)