

North Carolina Orthopaedic Clinic  
3609 Southwest Durham Drive  
Durham, NC 27707

Authorization for Disclosure of Health Information

I hereby authorize \_\_\_\_\_ to release medical information from the records of:  
(Name of Facility)

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Patient Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date(s) of Treatment Requested: \_\_\_\_\_

Information to be disclosed (check all applicable items to be released):

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> ER Record      | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Treatment Plans   |
| <input type="checkbox"/> Discharge Instructions        | <input type="checkbox"/> X-Rays Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Commitment Papers |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Lab Reports    | <input type="checkbox"/> Doctor's Orders    | <input type="checkbox"/> HIV testing       |
| <input type="checkbox"/> Consultations                 | <input type="checkbox"/> EKG/ECG Tests  | <input type="checkbox"/> Nurse's Notes      |  |
| <input type="checkbox"/> Operative Report              | <input type="checkbox"/> Therapy Notes  |   |  |
| <input type="checkbox"/> Other (please specify): _____ |   |   |  |

Purpose Or Need For The Disclosure Is:

- Continued Medical Care  Insurance  Legal  Patient's Own Use  Other \_\_\_\_\_

The Information May Be Disclosed To:

Recipient's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: \_\_\_\_\_ or upon the following event: \_\_\_\_\_  
(Date)

(If no date or event is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

\_\_\_\_\_  
(Signature of Patient or Personal Representative\*)

\_\_\_\_\_  
(Date of Signature)

\*If signed by a personal representative, a description of the representative's authority to act is as follows:

- Parent  Legal Guardian  Health Care Power of Attorney  
 Administrator  Executor of Estate  Next of Kin  Beneficiary