

Triangle Orthopaedic Associates PA
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PLEASE NOTE: THERE WILL BE A CHARGE FOR RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. (initials) _____

Please fax this release to 919-313-5201
If questions please call 919-220-5255

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social Security Number

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize _____ to release:
(patients name) (name of facility)

____ DISCHARGE SUMMARY

____ PATHOLOGY REPORTS

____ EMERGENCY REPORTS

____ HISTORY & PHYSICAL

____ LABORATORY REPORTS

____ ALL

____ PROGRESS NOTES

____ RADIOLOGY REPORTS

____ OPERATIVE NOTES

____ ECG/EEG/CARDIC CATH

From the time period of _____ to _____

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION TO BE RELEASED TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

REASON FOR RELEASE OF RECORDS:

____ REFERRAL TO SPECIALIST

____ INSURANCE

____ WORKERS COMP

____ CHANGE OF DOCTOR

____ LEGAL INVESTIGATION

____ DISABILITY DETERMINATION

____ PERSONAL

____ CONTINUING CARE

OTHER (SPECIFY) _____

Please provide current daytime telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named 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 individual or guardian or
Personal Representative of patient's estate

Date