



**Carolina  
Regional  
Orthopaedics**

2906 N. Main St.  
Tarboro, NC 27886  
P: 252/823-7212  
F: 252/823-5668

110 Patrick Ct  
Rocky Mount, NC 27804  
P: 252/443-0400  
F: 252/443-0572

... Improving the health of our communities

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Account Number \_\_\_\_\_

I, \_\_\_\_\_, \_\_\_\_\_  
Patient Name (First, Middle or Maiden, Last) (Date of Birth)

**Authorize:**

Name: \_\_\_\_\_

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

City,State,Zip: \_\_\_\_\_

Phone : \_\_\_\_\_

Fax: \_\_\_\_\_

**Disclose to:**

*Carolina Regional Orthopaedics  
110 Patrick Court  
Rocky Mount, NC 27804*

**or**

*Carolina Regional Orthopaedics  
2906 N. Main St.  
Tarboro, NC 27886*

**Please release:**

\_\_\_\_\_ Health Care Records from Office Visits.....(From \_\_\_\_\_ to \_\_\_\_\_)

\_\_\_\_\_ X-Rays done In-office

\_\_\_\_\_ Physical Therapy Records

**This disclosure is being made for the following purpose (please mark one):**

\_\_\_\_\_ Continuing Care

\_\_\_\_\_ Transfer of Care

\_\_\_\_\_ Attorney/Court Case

\_\_\_\_\_ Insurance

\_\_\_\_\_ Workers Compensation

\_\_\_\_\_ Personal Reasons

\_\_\_\_\_ Other (please describe reason) \_\_\_\_\_

**This authorization for disclosure of information is effective for one year from the date signed. This informed consent is subject to revocation at any time by written notification only.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Or

Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's appt is scheduled for: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ with Dr. \_\_\_\_\_