123 Hospital Drive
Tarboro, NC 27886
P: 252/ 823-7212
F: 252/ 823-5668

Rocky Mount Medical Park
901 N Winstead Ave, Suite 210
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:

Carolina Regional Orthopaedics
901 N Winstead Ave, Suite 210
Rocky Mount, NC 27804

To Disclose to:

Name: ______________________________

Address: ______________________________

City, State, Zip: _______________________

Phone: ______________________________

Attn: ______________________________

Appt: _______/_______/_______

Please release:

_____ Health Care Records from Office Visits…..(From ______________to______________)
_____ X-Rays done In-office
_____ Physical Therapy Records _____ EMG Report _____ Itemized Bill

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:________________

Paid: YES / NO Send: MAIL / PICK-UP (Call:(______) __________________)