

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
FROM CAPE FEAR ORTHOPAEDIC CLINIC**

Patient Name: _____ Birth Date: ____/____/____

Treatment Dates: _____ Patient's Identification/Chart #: _____

I HEREBY CONSENT TO AND AUTHORIZE CAPE FEAR ORTHOPAEDIC CLINIC, P.A. TO **RELEASE TO:**

Name of Facility/Individual to RECEIVE Information

Address

City

State

Zip Code

PROTECTED HEALTH INFORMATION (PHI) CONCERNING THE HISTORY, TREATMENT, AND/OR EXAMINATION OF THE ABOVE PATIENT. I UNDERSTAND THAT THE SPECIFIC TYPE OF PHI TO BE RELEASED INCLUDES:

The purpose for releasing this information is:

I understand the following:

- I understand that if the person or entity receiving Patient Health Information (PHI) is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Cape Fear Orthopaedic Clinic, P.A. in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cape Fear Orthopaedic Clinic, P.A. before receiving the revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- [ALTERNATIVE, IF APPLICABLE]: I understand that Cape Fear Orthopaedic Clinic, P.A. may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that Cape Fear Orthopaedic Clinic, P.A. will not provide such research-related treatment unless I provide the authorization. **NOTE:** If this provision is applicable, the third party for whom the information is being created must be listed as the facility/individual to whom Protected Health Information (PHI) is to be released to. Also, the purpose for which the information is to be created and disclosed must be listed under the purpose for releasing this information.
- [FOR MARKETING AUTHORIZATIONS ONLY, IF APPLICABLE]: I understand that the person or entity I am authorizing to use and/or disclose Protected Health Information (PHI) for marketing purposes may receive either direct or indirect compensation for doing so.

Signature of Patient or Legal Representative

Date

State Relationship to Patient

Date

Signature of Witness

Date

****Note: This authorization expires at the earlier of one year (365 days) OR the date the following event occurs:**

FOR OFFICE USE ONLY

Date Completed: _____

Staff Initials: _____

Information Released from the following DRS: Electronic Medical Record (EMR) Paper Chart Canofile CD
 Digital Radiology Films Traditional Radiology Films Billing/Payment Information