AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Cape Fear Orthopaedic Clinic, P.A. to disclose (release) the following information from the medical records of:

Patient Name: ______________________________ Date of Birth: ______________

Address: ____

Telephone: ________________________ Medical Record Number: ________________

Covering the period(s) of health care:

From ______________ to ______________

From ______________ to ______________

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ History and Physical Examination
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-ray reports
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- ☐ Mental health care or services
- ☐ Psychotherapy Notes
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Photographs, videotapes, digital or other images

☐ Other (please specify) ____

____

This information is to be disclosed <u>to</u> the following individual or entity for the purpose of:

____

____

Name: ______________________________ Relationship: ______________________

Address: ____

Telephone: ________________________

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The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of ____.

Initials: ______________

b. I understand that I may revoke this authorization at any time by notifying Cape Fear Orthopaedic Clinic, P.A. in writing, but if I do it won't have any effect on any actions Cape Fear Orthopaedic Clinic, P.A. took before it received the revocation.

Initials: ______________

c. I understand that Cape Fear Orthopaedic Clinic, P.A. cannot make me sign this authorization as a condition to receive treatment from Cape Fear Orthopaedic Clinic, P.A. except:

(i) when Cape Fear Orthopaedic Clinic, P.A. provides me with research-related treatment; or

(ii) when Cape Fear Orthopaedic Clinic, P.A. provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials: _________________

Cape Fear Orthopaedic Clinic, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

____
Signature of Patient or Representative

____
Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____

____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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