AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM CAPE FEAR ORTHOPAEDIC CLINIC, P.A.
4140 Ferncreek Drive, Suite 801, Fayetteville, NC 28314

Patient Name:_____ Birth Date:____/____/____
(Print or Type)

Treatment Dates:_____ Patient's Identification/Chart NO:_____

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 my 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

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

_____