

MOORE ORTHOPEDICS AND SPORTS MEDICINE

4251 B Arendell Street Morehead City, North Carolina 28557
phone: 252 808-3100 fax: 252 808-3120 www.mooresportsmed.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PRINT PATIENTS FULL NAME _____

BIRTH DATE (MO/DAY/YR) _____

STREET ADDRESS _____

SOCIAL SECURITY NUMBER _____

CITY, STATE, ZIP _____

HOME PHONE _____

At the request of the individual, I _____, do hereby authorize _____ to release:
PATIENT NAME NAME OF FACILITY

DATES OF _____

- DISCHARGE SUMMARY
- HISTORY & PHYSICAL
- PROGRESS NOTES
- OPERATIVE NOTES
- PATHOLOGY REPORTS
- LABORATORY REPORTS
- RADIOLOGY REPORTS
- ECG/EEG/CARDIAC CATH
- EMERGENCY REPORTS
- FINANCIAL

I DO I DO NOT Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

NAME OF COMPANY/AGENCY/FACILITY/PERSON _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PURPOSE OF DISCLOSURE:

- REFERRAL TO SPECIALIST
- LEGAL INVESTIGATION
- OTHER (specify) : _____
- INSURANCE
- DISABILITY DETERMINATION
- WORKERS COMP
- PERSONAL
- CHANGE OF DOCTOR
- CONTINUING CARE

Please provide current telephone number in the event we need to contact you: _____

List others we may release or share information with: _____

I hereby authorize disclosures of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

SIGNATURE OF INDIVIDUAL OR GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE _____

DATE _____

NOTE: There will be a charge for a personal copy of the permanent transfer of your records.

Entire _____

DS _____

OP _____

HP _____

Number of Pages _____

Lab _____

EKG _____

X-RAY _____

Path _____

EKG _____

Immune _____

Other _____

ROI SPECIALIST _____

DATE _____