CAROLINA BONE & JOINT, PA
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print – Patient's Full Name) Birthdate (Month/Day/Year)

_____ _____
(Street Address) Daytime Telephone Number

_____
(City, State, Zip Code)

I HEREBY AUTHORIZE:

☐ 10460 Park Road, Charlotte, NC 28210, Fax: 704.602.0031
☐ 701 E. Roosevelt Blvd, Bldg. 600, Monroe, NC 28112, Fax: 704-289-5829
☐ 1331 N. Elm St., Suite 101, Greensboro, NC 27401, Fax: 336.274.6994
☐ 1 Wellness Blvd, Ste 104, Irmo, SC 29063, Fax: 803-227-4875

TO RELEASE INFORMATION TO:

_____
Name of Company/Agency/Facility/Person

_____ _____
Phone Number Street Address

_____ _____
City, State, Zip Code Fax Number

PLEASE CHECK THE INFORMATION TO BE RELEASED AND THE RELATED DATE(S) OF SERVICE:

Date from:_____ Date to:_____

☐ All Records ☐ Clinical Notes ☐ Radiology Reports ☐ Operative Notes
☐ Medication Lists ☐ Therapy Notes ☐ Work Status Forms
☐ Other _____

PURPOSE OF DISCLOSURE:

☐ Referral to Specialist ☐ Insurance ☐ Workers' Comp ☐ Change of Doctor
☐ Legal Investigation ☐ Disability Determination ☐ Personal ☐ Other_____

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 affect any information released prior to notification of cancellation. I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

_____ _____
Signature of Individual **Date**

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative **Legal Relationship** **Date** **Witness**