

**NC Orthopaedic Clinic**  
**3609 Southwest Durham Dr, Durham, NC 27707**  
**Phone- 919-403-5140, Fax- 919-477-1929**  
**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
**(Print patient's full name)**

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
(Street address)

\_\_\_\_\_  
social security number

\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
Phone (Home)

\_\_\_\_\_  
Email address

At the request of the individual, I \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release:

\_\_\_\_\_  
**(patient's name)**

\_\_\_\_\_  
**(name of facility)**

\_\_\_\_\_  
PROGRESS NOTES

\_\_\_\_\_  
PATHOLOGY REPORTS

\_\_\_\_\_  
ALL RECORDS

\_\_\_\_\_  
OTHER DOCTORS NOTES

\_\_\_\_\_  
LABORATORY REPORTS

\_\_\_\_\_  
OTHER \_\_\_\_\_

\_\_\_\_\_  
OB/GYN NOTES

\_\_\_\_\_  
RADIOLOGY REPORTS

\_\_\_\_\_  
HOSPITAL NOTES

\_\_\_\_\_  
ECG/EEG/CARDIC CATH

\_\_\_\_\_  
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 (Physician, hospital, agency, etc)

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, state, zip

**PURPOSE OF DISCLOSURE:**

\_\_\_\_\_  
REFERRAL TO SPECIALIST

\_\_\_\_\_  
INSURANCE

\_\_\_\_\_  
WORKERS COMP

\_\_\_\_\_  
LEGAL INVESTIGATION

\_\_\_\_\_  
DISABILITY DETERMINATION

\_\_\_\_\_  
PERSONAL

OTHER (SPECIFY) \_\_\_\_\_

I hereby authorize disclosure 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**

Reason for transferring: \_\_\_\_\_

Please provide current telephone number in the event we need to contact you: \_\_\_\_\_ -

**NOTE: THERE WILL BE A CHARGE FOR RECORD IN ACCORDANCE WITH THE \$.75 (PER PAGE 1 TO 26 PG) ADDITIONAL \$.50 PER PAGE (FROM PAGE 26 TO 100) ADDITIONAL \$.25 PER PAGE (FROM PAGE 101 & UP) + ACTUAL POSTAGE. HEALTHPORT HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY.**

Entire \_\_\_\_\_ LAB \_\_\_\_\_  
IMM \_\_\_\_\_ EKG \_\_\_\_\_

mammogram \_\_\_\_\_  
number of pages \_\_\_\_\_

HEALTHPORT ROI SPECIALIST

\_\_\_\_\_  
Date