orthopaedicseast
& SPORTS MEDICINE CENTER

OFFICE USE ONLY

CHART # _____

DATE RECEIVED: _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Orthopaedics East & Sports Medicine Center, Inc. (OE) to use or disclose the specific health information identified below for:

Patient: _____ DOB: ____/____/____

Address: _____ City: _____State: ____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

DESCRIPTION OF HEALTH INFORMATION BEING REQUESTED

I authorize the use or disclosure of the following health information created or maintained by OE:

☐ All of my individually identifiable health information (including Medical Record) for
☐ All Dates of Service or ☐ From ____/____/____ to ____/____/____
Include X-Rays ☐ Yes ☐ No

☐ Other: Please Specify Specific Record (Ex: PT note, MRI report, CT scan, etc.) _____

PARTY AUTHORIZED TO RECEIVE HEALTH INFORMATION

Name of party authorized to receive health information: _____
These records are for: ☐ Patient ☐ Physician ☐ Other

These records are to be:
☐ Picked Up ☐ Mailed ☐ Faxed _____ ☐ Emailed_____
Fax Number Email Address

Mailing address of party authorized to receive health information, if different than address listed above:

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

ACKNOWLEDGMENT

The purpose of this authorization is at my request. I understand that, if the person or organization receiving this information is not a healthcare provider, health care organization, or health plan covered by federal regulations, then this information may be redisclosed and is no longer protected by these regulations. I understand that I am entitled to receive a copy of this authorization after I sign it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. OE may not refuse to treat me if I do not sign it. I understand that I will be provided with the first copy of my record at no cost, but will be charged a $6.50 fee for additional requests. Records sent directly to a physician's office involved in your medical care will be provided at no cost.

I understand this this request may take approximately 5-7 business days to complete for paper medical records. I understand that if I elect to receive records by email and my information is transmitted without encryption security I accept the security risks to my health information that could result by sending my information electronically by email.

I understand that I may revoke this authorization at any time by delivering a written, signed revocation to Orthopaedics East & Sports Medicine Center, Inc., Attention: Privacy Officer, 810 W. H. Smith Blvd. Greenville, N. C. 27834; however, such revocation does not affect any actions taken by OE before my written revocation is received by OE. Unless revoked earlier, this authorization to use or disclose my health information will expire five years from the date of this authorization.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to patient: _____

Copy given to patient by: _____ Identification verified: ☐ Yes ☐ No