PINEHURST ORTHOPEDIC GROUP, P.A.
Authorization to Release Health Information

Patient Information

Name of Patient _____ Date of Birth _____

Address _____
City, State, Zip _____

Name and Address of Covered Entity Authorized to Release Information:

PINEHURST ORTHOPEDIC GROUP, P.A.
PO BOX 759
PINEHURST NC 28370
(910) 295-7447

Forward Information to: _____
_____
_____

The information below will be used for patient care. (Description of PHI needed)
☐ Clinic Notes ☐ OP Reports ☐ Imaging reports (written and disc) ☐ ER reports
☐ Lab ☐ Pathology ☐ Admission/Discharge reports

This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to:

PINEHURST ORTHOPEDIC GROUP, P.A.
PO BOX 759
PINEHURST NC 28370
FAX# (910) 295-7447

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)