Experience in Motion
MOORE ORTHOPEDICS
AND SPORTSMEDICINE

4218-M Arendell Street, Morehead City, NC
Phone 252-808-3100 | Fax 252-808-3120

1165-M Cedar Point Blvd, Cedar Point, NC
Phone 252-808-4450 | Fax 252-764-2442

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 _____ (PATIENT NAME), do hereby authorize _____ (NAME OF FACILITY) to release:

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
- ❑ INSURANCE
- ❑ DISABILITY DETERMINATION
- ❑ WORKERS COMP
- ❑ PERSONAL
- ❑ CHANGE OF DOCTOR
- ❑ CONTINUING CARE
- ❑ OTHER (specify) : _____

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.