PERFORMANCE

ORTHOPAEDICS • SPORTS MEDICINE • SHOULDER SURGERY • PHYSICAL THERAPY

3701 Northwest Cary Parkway, Suite 305 • Cary, NC 27513 Ph (919) 882-6100 Fx (919) 877-4797

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name:Last________________ First________________ Middle__________

Date of Birth________________ Social Security #________________

Home Phone______________ Mobile Phone______________ Business Phone______________

INDIVIDUAL/ORGANIZATION TO RELEASE MEDICAL RECORDS	**RECIPIENT OF MEDICAL RECORDS**
Performance Orthopaedic Surgery & Sports Medicine, P.A. 3701 NW Cary Parkway, Ste. 305 Cary, NC 27513 P (919)882-6100 F (919)877-4797 or ______________________ ______________________	Performance Orthopaedic Surgery & Sports Medicine, P.A. 3701 NW Cary Parkway, Ste. 305 Cary, NC 27513 P (919)882-6100 F (919)877-4797 or ______________________ ______________________

The medical records are to be disclosed for the following purpose:
☐ at the request of the patient
☐ other:________________________________

The type and amount of information to be used or disclosed is as follows:
DATES: ☐ All Dates ☐ Date Range________________________
CONTENT:

☐ Complete Medical Record
☐ Office/Consultation Reports
☐ Radiology Reports
☐ Operative Reports
☐ Laboratory Reports
☐ Other________________________

By signing, I authorize Performance Orthopaedic Surgery & Sports Medicine, P.A. and the above individual/organization to use and/or disclose certain protected health information (Medical Records) about me as detailed in this form.

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules.
I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted in writing directly to POSSM. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I hereby release POSSM from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire twelve (12) months from the date signed. This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

Signature of Patient or Legal Guardian________________________ Date______________

Name of Patient or Legal Guardian________________________________