PERFORMANCE
ORTHOPAEDICS • SPORTS MEDICINE • SHOULDER SURGERY • PHYSICAL THERAPY
1001 Darrington Drive Suite 100, 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

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

_____
_____
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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

_____
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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_____