Georgetown Orthopaedics

2185 North Fraser Georgetown, SC 29440
Phone: 843-527-1800 Fax: 843-527-6528

Authorization for Use or Disclosure of Protected Health Information

Patient name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Evening Phone: _____

I authorize Georgetown Orthopaedics to use or disclose my protected health information as indicated below to:

_____
(name of entity to receive this information)

_____
Address City State Zip Code

_____
Phone Number Fax Number

I authorize _____ to release my protected health information to Georgetown Orthopaedics as indicated below.

Information to be released:
From/to dates:_____
- o History and Physical Exam
- o Office Notes
- o X-ray or MRI Films
- o Lab or X-ray Reports
- o Hospital Records (Op Notes, Discharge Summary)
- o Insurance/Workers Compensation
- o Other _____

Purpose for Release:
- o Changing Physician
- o Continuing Care
- o At Patient Request
- o Second Opinion
- o Legal
- o School
- o Medication records
- o Other_____

I understand that this authorization will expire: _____
(date of expiration)

I understand that I may revoke this authorization by written notification. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian Date