



Please fax to **Scanstat in Medical Records: 919-313-5201**

Phone: 919-281-1839

Request for Protected Health Information / Patient Authorization for Release of Records

Patient Name: _____	S.S. # _____
Date of Birth _____	Patient Phone Number(s): _____ MR/Chart Number _____

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE:

EmergeOrtho _____ or
 120 William Penn Plaza
 Durham, NC 27704

RELEASE INFORMATION TO: *(recipient of disclosure)*

Name: _____

Address: _____

Apt, Suite or PO #: _____

City, State, and Zip: _____

Phone: _____

Fax: _____

***There is a charge for records for personal use/patient pick up. If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged.**

TREATMENT DATES TO BE DISCLOSED: _____

PURPOSE OF THE DISCLOSURE: Insurance Legal Continuing Care Personal Other (specify) _____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

Rehabilitation/Therapy Notes Radiology Behavioral Therapy Radiology Films Other

SPECIFIC INFORMATION TO NOT BE DISCLOSED: _____

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 to the HIM Department at EmmergeOrtho, P.A. 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 understand that I will be given a copy of this authorization upon my signature.

I hereby authorize EmmergeOrtho, P.A and or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release EmmergeOrtho, P.A and/or ScanSTAT Technologies 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 90 days 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.

PATIENT'S SIGNATURE

DATE

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN

DATE

WITNESS

DATE