RALEIGH ORTHOPAEDIC CLINIC, P.A.
3001 EDWARDS MILL RD SUITE 200
RALEIGH, NC 27612

CONSENT FOR RELEASE OF MEDICAL INFORMATION

1. I hereby authorize:_____
(Medical practice)
Phone #_____Fax#_____to release information including, if any, psychiatric or psychological information, infectious or contagious disease information (including HIV/AIDS confidential information), and/or information about drug or alcohol abuse or treatment of same from the health record(s) of:

Patient Name: _____

Date of Birth:

Covering Period of treatment FROM: _____ TO: _____

2. Information to be released: check one
☐ COMPLETE RECORD
☐ OTHER, specify: .....

3. Information is to be released to:

Name: Raleigh Orthopaedic Clinic

Address: 3001 Edwards Mill Rd. Suite 200 Raleigh, NC27612

Appointments Fax: 919-863-6908

4. Purpose of Disclosure:

_____

5. I hereby release_____and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this Consent for Release of Medical Information.

6. I understand that this Consent for Release of Medical Information is subject to revocation by the undersigned at any time, except to the extent that action has already been taken by _____ in reliance upon this consent. Unless otherwise stated below, this consent shall automatically expire one year from the date set forth below.

7. I have read and understand the Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

SIGNED: (Patient or Legal Representative) _____

DATE OF SIGNATURE: _____