OrthoNC
COMPREHENSIVE + MODERN + PERSONALIZED

AUTHORIZATION FOR RELEASE OF PHI

PO Box 1107 Wake Forest, NC 27588
Phone (919) 562-9410 Fax (866) 328-9959
Email: orthonc@verisma.com

PATIENT INFORMATION:

Last Name ______ First Name ______ Date of Birth ______

Street Address / Apt# (Include Complete Mailing Address) ______ Social Security # ______

City ______ State ______ Zip Code ______ Telephone Number ______

PERSON(S) / ORGANIZATION(S) AUTHORIZED TO MAKE DISCLOSURE: ORTHOPAEDIC SPECIALISTS OF NORTH CAROLINA.

RELEASE AND DISCLOSE MY PHI TO (Recipient of Use / Disclosure):

Name ______ Fax Number ______

Street Address / Apt# or Suite (Include Complete Mailing Address) ______ Telephone Number ______

City ______ State ______ Zip Code ______ Fax Number ______

DELIVERY METHOD FOR DUPLICATION OF RECORDS:

❑ MAIL PAPER DUPLICATION ❑ MAIL CD/DVD DIGITAL DUPLICATION ❑ FAX DUPLICATION
❑ PICK UP PAPER DUPLICATION ❑ EMAIL/ELECTRONIC DIGITAL DUPLICATION – **Please see page 2 of this release form.**
DIGITAL DUPLICATION WILL BE PROVIDED IN PDF FORMAT. YOU CAN OBTAIN A COPY TO ADOBE READER AT http://www.adobe.com/

TREATMENT DATE(S) TO BE USED/DISCLOSED: From ______________________________ **to** ______________________________

DESCRIPTION OF INFORMATION TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) PROVIDED:

❑ Abstract/Summary of Medical Records for personal or physician use ❑ Complete Medical Records

"OR" SPECIFIC DOCUMENT(S) TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) PROVIDED:

❑ Clinic/Office Note(s) ❑ Laboratory Report(s) ❑ Diagnostic Test/Report(s)
❑ Consultation(s) ❑Operative Report(s) ❑ Radiology CD/Film(s)
❑ Pathology Report(s) ❑ Itemized Bill(s) ❑ Other, specify ______________________________

This information may include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.

SPECIFIC INFORMATION NOT TO BE DISCLOSED: ______________________________

THIS INFORMATION IS TO BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE(S): (check all that apply)

❑ Continuation of Care ❑ Patient Transfer ❑ Legal ❑ Insurance ❑ Legal ❑ Other- explain ______________________________

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MAIL/ELECTRONIC DELIVERY NOTICE:

I understand Emails can be intercepted, altered, forwarded, or used without authorization or detected. Emails can be circulated, forwarded and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed, lost during creation and transmission due to technical failure. I understand and accept the risk using an unsecure email. I agree for Orthopaedic Specialists of North Carolina and/or Verisma to email me my protected health information when the email delivery method is chosen and I fully understand the risk involved in using the email delivery method. ***PLEASE SIGN IF YOU AGREE AND ACKNOWLEDGE –*** ____________________________

PLEASE PROVIDE AN EMAIL FOR ELECTRONIC DELIVERY

PLEASE PROVIDE A PREFERED PASSWORD MUST CONTAIN 8 TO 12 CHARACTERS

DUPLICATION FEES FOR PATIENTS AND THEIR LEGALLY APPOINTED REPRESENTATIVES
(Durable Healthcare Power of Attorney, Parent or Legal Guardian)

Paper fee for copies of records:
Pages 1-10 = $0.50 per page
Pages 11+ = $0.25

Fee for electronic duplication of records:
$14.85 per CD

Payment options are: Check, Money Order, Visa, MasterCard or Discover. Please make checks payable to Verisma. Questions regarding your invoice may be answered at 770-569-2445.

- Unless withdrawn, this consent will **expire 90 days** from the date signed unless another date or event is specified. ____________________
- By signing this form, **I agree to pay any duplication fees or charges** for this information at the time or service or when applicable.
- If preferred delivery method is unavailable at the time of service, I authorize that this information to be mailed or faxed.
- 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 Privacy Officer at Orthopaedic Specialists of North Carolina.
  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 Orthopaedic Specialists of North Carolina and or Verisma to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release Orthopaedic Specialists of North Carolina and/or Verisma 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 via mail, fax, and/or electronic delivery.

____ ____________________
Signature of Patient — Date

____ ____________________
Parent / Legally Authorized Representative / Relationship to Patient — Date

____ ____________________
Witness — Date