Carolina Orthopaedic & Neurosurgical Associates

1330 Boiling Sprgs. Rd., Ste 1600
Spartanburg, SC 29303
864-582-6396
Fax- 864-542-2939

115 Deacon Tiller Ct.
Duncan, SC 29334
864-721-0025
Fax- 864-721-0035

1075 Boiling Springs Rd.
Spartanburg, SC 29303
864-538-7265
Fax 8645-591-0422

Request for Access to Patient's Health Information / Authorization for Release of Medical Information

Patient Name: _____ **Date of Birth:** _____

Social Security #: _____ **Patient Phone #:** _____

Date of access / release request: _____

At the request of the individual, I _____ do hereby authorize_____
(Patient Name) (Facility Name)

Dates of: _____

_____ Progress Notes _____ Discharge Summary _____ EMG/NCS
_____ Operative Notes _____ History & Physical _____ Laboratory Reports
_____ Physical Therapy Notes _____ Radiology Reports/Films _____ Emergency Reports
_____ Other

_____ *** All information pertaining to the dates of treatment listed above

Information Release To:

Facility, Company, Person, Agency: _____

Address: _____

Phone/Fax #: _____

I understand that Carolina Orthopaedic & Neurosurgical Associates may charge me all applicable copy fees and / or postage fees for a personal copy or for the permanent transfer of your records.

Purpose of Disclosure:

_____Referral to Specialist _____Insurance _____Workers' Comp.
_____Legal / Attorney Request _____Disability Determination _____Change of Physician
_____Personal _____Continuing Care
_____Other (Specify) _____

I hereby authorize disclosure of the health information for the above patient. I understand that Carolina Orthopaedic & Neurosurgical Associates is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that Carolina Orthopaedic & Neurosurgical Associates may extend the deadline by an additional thirty days if I am notified in writing of the extension. I understand that this authorization is valid until a written notification is received to cancel. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would no longer be protected by federal regulations.

By signing below, I acknowledge and agree to the above conditions.

_____ _____
Signature of Patient/Guardian/Representative **Date**