Authorization To Obtain PHI (Personal Health Information) From Another Entity

I hereby authorize and request you send my medical records to:

Guilford Orthopaedic & Sports Medicine Center
A Division of Southeastern Orthopaedic Specialist, P.A.
1915 Lendew Street
Greensboro, NC 27408
(336) 275-3325 Telephone
(336) 275-5346 Fax

From: ____
Physician/Hospital/Company

Address: ____
Street City/State Zip Code

Telephone #: ______________________ Fax #: ______________________

(please provide a specific description of the information to be released)

Complete Records ______ Partial Records _________ please specify below
○ Office Notes ○ X-ray/MRI/CT ○ Other ______________________
Release my PHI from: Date: ______________________ To: ______________________

Patient's Name: ______________________ Date of Birth: ______________________

Home Telephone #: ______________________ Cell #: ______________________

Address: ____
Street City/State Zip Code

____
Patient/Legal Guardian/Authorized Person Signature Relationship to Patient Date

Authorization will expire 12 months from date of signature unless otherwise noted.
Expiration Date: __________

Your PHI (Personal Health Information) will be used for treatment, payment, and health care operations. To revoke this authorization, it must be submitted in writing to Guilford Orthopaedic, A Division of Southeastern Orthopaedic Specialist, P.A.