Authorization to release PHI (Personal Health Information)

FOR DISABILITY

I hereby authorize Guilford Orthopaedic, A Division of Southeastern Orthopaedic Specialists, P.A. to release my PHI verbally and/or in writing. This authorization is for my injury/illness **beginning** _____ to the end of treatment. Release to:

_____

Disability Insurance Company and/or Employer

_____

Address

_____

Phone Number/Fax Number Claim Number/Policy Number

Representative Name: _____

THERE IS A SERVICE FEE OF $20.00 FOR THE COMPLETION OF EACH FORM

Patient's Name: _____ Date of Birth_____

Social Security #:_____ Telephone #: _____

Address: _____

Street City/State Zip Code

_____

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

_____

To revoke this authorization it must be submitted in writing to Guilford Orthopaedic, A Division of Southeastern Orthopaedic Specialists, P.A.
There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).

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