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

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

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

To: ____
Physician/Hospital/Company

Address: ____
Street City/State Zip Code

Telephone #: ____________________ Fax #: ____________________

Information To Be Released (please provide a specific description of the information to be released)

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Release my PHI from: Date: ____________________ To: ____________________

Patient's Name: ____________________ Date of Birth: ____________________

Home Telephone #: ____________________ Cell #: ____________________

Address: ____
Street City/State Zip Code

____
Signature of Patient Date

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

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.