Authorization to release PHI (Personal Health Information)

FOR DISABILITY

I hereby authorize 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 $10.00 FOR THE COMPLETION OF FORMS

Patient's Name: _____ Date of Birth _____

Social Security #:_____ Telephone #: _____

Address: _____

Signature: _____Date: _____

To revoke this authorization it must be submitted in writing to 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).

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