Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:

____

Physician/Hospital/Insurance Company/Employers
Do not use for Attorney's

____

Address

____

Phone Number/Fax Number   Claim Number/Policy Number

THERE IS A SERVICE FEE FOR PATIENTS TO RECEIVE THEIR RECORDS

Patient's Name: ______________________ Date of Birth ____________

Social Security #: ______________________ Telephone #: ____________

Address: ____

Signature: ______________________ Date: ____________

Expiration Date (how long we are authorized to release records): ____________

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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).

Guilford Orthopaedic & Sports Medicine Center
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