Authorization to release PHI (Personal Health Information)

I hereby authorize Guilford Orthopaedic, A Division of Southeastern Orthopaedic Specialists, P.A. to release my PHI to: Physician/Hospital/Insurance Company/Employers Do not use for Attorney's Complete Address Phone Number Fax Number Claim Number/Policy Number Attention: THERE IS A SERVICE FEE FOR REPRODUCING PATIENT RECORDS (please provide a specific description of the information to be released) o Office Notes from ______ to _____ o X-ray/MRI/CT from ______ to _____ Patient's Name: _____ Date of Birth: _____ Social Security #:______ Telephone #: _____ Address: ____ Street City/State Zip Code

To revoke this authorization it must be submitted in writing to Guilford Orthopaedic, A

Authorization will expire 12 months from date of signature unless otherwise noted.

Date

Patient/Legal Guardian/Authorized Person Signature Relationship to Patient

Expiration Date _____

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 Specialist, P.A.

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