PORT CITY ORTHOPAEDICS PLLC

DERRICK G. HICKEY, MD

Authorization to Release Medical Information FROM Port City Orthopaedics, PLLC

Patient Name _____ DOB _____
Current Address _____City _____State ____Zip _____
Daytime Phone # _____ Evening Phone #_____ SS# _____

I authorize information released to:

_____
Physician/or other third party named/or self

_____ OR E-MAIL ADDRESS: _____
Address

_____ OR FAX #: _____
City, State, Zip

INDICATE TYPE OF INFORMATION TO BE RELEASED BELOW

__ **General Medical Records** – excluding protected records.
Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports and immunizations.

OR Specific Information Only:

__ History and Physical specify date _____
__ Medications/Therapy
__ X-ray reports
__ Films specify type or date _____
__ Operative report specify type or date _____
__ Accident or injury dates from _____ to_____
__ Other _____

_ Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT _____ SEXUALLY TRANSMITTED DISEASES
INITIAL INITIAL

_____ ALCOHOLISM DIAGNOSIS/TREATMENT _____ AIDS/HIV TEST RESULTS
INITIAL INITIAL

_____ MENTAL HEALTH/TREATMENT _____ GENETIC TESTING
INITIAL INITIAL

- □ By signing this form, you are authorizing the use or disclosure of your protected health information as described above. Thisinformation may be redisclosed if the recipient is not required by law to protect the privacy of the information.
- □ You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.
- □ You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

_____
Signature of patient or legally responsible person relationship to patient date Date

5302 OLEANDER DR
WILMINGTON, NC 28403
TEL: 910-791-4492
FAX: 910-791-4355