

PORT CITY ORTHOPAEDICS, PLLC

DERRICK G. HICKEY, MD

Authorization to Release Medical Information TO Port City Orthopaedics, PLLC

Patient Name _____ DOB _____
Current Address _____ City _____ State _____ Zip _____
Daytime Phone # _____ Evening Phone # _____ SS# _____

I authorize information released from:

Physician/or other third party named

Please fax medical records indicated to:

Address

Attn: PCO Medical Records 910-791-4355.

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.

INITIAL INITIAL DRUG ABUSE DIAGNOSIS/TREATMENT

SEXUALLY TRANSMITTED DISEASES

INITIAL INITIAL ALCOHOLISM DIAGNOSIS/TREATMENT

AIDS/HIV TEST RESULTS

INITIAL INITIAL MENTAL HEALTH/TREATMENT

GENETIC TESTING

- By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information 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

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WILMINGTON, NC 28403
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FAX: 910-791-4355