210 Village Center Blvd. Suite 200, Myrtle Beach, SC 29579
Phone: 843-353-3460 Fax: 843-353-3461

Authorization to Disclose Protected Health or Billing Information

Patient Information: I give permission to release the health information of:

Patient Name:_____ DOB: _____

Street Address: _____

City, State, Zip:_____

Telephone: (_____) _____ Email address: _____

Although OrthoSC will use reasonable means to protect the security and confidentiality of emails sent and received, we cannot guarantee the security and confidentiality of all email communications.

Release Information From:

OrthoSC ☐

Strand Orthopaedic Consultants ☐

Carolina Orthopaedic Specialists ☐

Coastal Orthopedics ☐

Other:_____

_____

Release Information To:

OrthoSC ☐

Other:_____

_____

_____

_____

Purpose of Release (check reason):

- o Request of individual / personal
- o Insurance
- o Doctor Requesting
- o Disability
- o Workers Compensation
- o Legal purpose including discussions & proceedings
- o Other:_____

Records to be release (check all that may apply):

- o Office Visit Notes
- o Laboratory Reports
- o X-Ray - Reports
- o X-Ray Burnt on Disk
- o MRI – Reports or Films (Please circle)
- o Billing Information
- o Notes during specific time frame: ____/____/____ to ____/____/____
- o Other_____

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- A fee may be charged for providing the protected health information, please discuss with medical records clerk.
- I have a right to receive a copy of this form upon request. This request is valid for 90 days from signature date.

Signature: _____ **Print name:**_____

Date/Time: _____ **Relationship to patient:** _____

OFFICE USE ONLY: Records sent/ Picked up: ____/____/____ Given By:_____(Employee Signature)