Cape Fear Sports Medicine, P.A.
6019 Oleander Drive, Suite 200 * Wilmington * NC * 28403
910-790-9714 * Fax 910-791-1063

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the custodian of records of Cape Fear Sports Medicine, PA to disclose/release my individually identifiable health information as described below.

Patient Name: _____
Address: _____
_____
Phone: _____Cell Phone:_____
SSN: _____ Date of Birth:_____/_____/_____

Please check the specific information to be released (used or disclosed) and the related date(s) of service: (check all applicable):

Date from:_____ Date to:_____ Pertaining to:_____

- ☐ Clinical notes
- ☐ X-ray CD or Films
- ☐ Billing records
- ☐ Operative note
- ☐ Other (describe specifically) _____
  _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Copy Fees: Medical record copies will be provided to you at a **minimum fee** of $10.00 per request. X-ray CD's will be provided to you for a fee of $10.00 per requested CD. *Please note that originals will not be released.*

The information may be used/disclosed for: ☐For my healthcare ☐Legal Review ☐Insurance Review ☐For employment purposes ☐Other_____

I authorize Cape Fear Sports Medicine, PA to release the requested information to:

Name / Organization: ☐Self or _____
(Healthcare Provider / Insurance / Attorney)

Address:_____

City:_____ State:_____ Zip:_____

Telephone #: ___ ___ ___/___ ___ ___/___ ___ ___ ___ Fax #: ___ ___ ___/___ ___ ___/___ ___ ___

Please check the preferred method for releasing the requested information:

- ☐ I will pick up
- ☐ I will have someone pick up for me
- ☐ Fax to the number above
- ☐ Mail to the address above

Individual's Name:_____ Relationship: ☐Spouse ☐Parent ☐ Child ☐Other_____

I understand that if the person or entity that receives this information is not a health plan or healthcare provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal state law. I understand that I may revoke this authorization, except to the extend the custodian has relied on it, by sending a written request to the Privacy Liaison, 6019 Oleander Drive, Suite 200, Wilmington, NC 28403.
This authorization will expire in **90 days**, unless otherwise noted.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*

It may take 7-10 business days to process your request