Patient Acct#________________

# Blue Ridge Bone & Joint

129 McDowell Street
Asheville, NC 28801
Phone: 828-258-8800 Fax: 828-281-7570

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Blue Ridge Bone & Joint to **""""SEND/""""RECEIVE (circle one)** information from the medical records of:

PATIENT NAME _______________________________________DATE OF BIRTH_____________SSN_______________________

PATIENT ADDRESS________________________________________________________________________________
STREET CITY& STATE ZIP CODE

HOME#______________________ CELL#______________________ WORK#______________________

These records will be **""SENT TO/"""RECEIVED FROM (circle one)**: ATTN________________________________

NAME OF PERSON OR FACILITY_____________________________________________________PHONE#________________________

ADDRESS_____________________________________________________________ FAX#________________________
STREET CITY& STATE ZIP CODE

RECORDS TO BE SENT BY: MAIL PATIENT TO PICK-UP

INFORMATION TO BE RELEASED: **(PLEASE CHECK INFORMATION REQUIRED)**

____Office Notes
____Operative Notes
____X-ray Reports
____X-ray Disk/Film
____MRI Report
____MRI Films

____Physical Therapy Notes
____Lab/Pathology Reports
____EEG,U/S, EMG/NCV
____Return to Work Note
____Disability Forms
____Billing Inquiry

____All Records
____Other______________
______________________
______________________
______________________

DATES OF SERVICE REQUESTED: _____________________________________________

PURPOSE OF DISCLOSURE: ____Workers' Compensation ____Continued Patient Care ____Insurance

____Personal Use Other________________________________________________

- We may charge you a reasonable fee for copying and mailing of medical records.
- If X-ray films are requested, there is a charge for copies at $4.00 a sheet for X-rays taken before 2/12/2008 or $5.00 per disk for X-rays taken after 2/12/2008.

I understand the information released is for the specific purpose above and may not be provided in whole or part to any other agency, organization, or person not listed on this authorization. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. I understand it may not be possible to ensure my right to the protection of the privacy of this information once BRBJ discloses it to another party. I understand I may revoke or terminate this authorization. This authorization will **expire in one (1) year unless a date or event is written in the blank provided below**.

**EXPIRATION DATE:**________________________

********INSTRUCTIONS: MAKE SURE ALL BLANKS ARE FILLED IN. FAILURE TO DO SO MAY PREVENT OR DELAY RELEASE OF INFORMATION********

Patient Signature__________________________________________________ Date______________________

Signature of Patient Representative_______________________________ Relationship to Patient______________________

Rev. 03/10