Campbell Clinic ORTHOPAEDICS

PATIENT DIRECTED RELEASE OF INFORMATION
(All sections must be completed)

Patient name: _____ DOB: _____

I hereby authorize release of my medical records to:

Name: _____ Fax: _____

Address: _____

Email: _____

Purpose of disclosure: Disability benefits and/or FMLA information

Method of disclosure: ☐Fax ☐Mail ☐Email ☐Pick-Up

This authorization applies to:
☐Health care information relating to the following treatment, condition, or dates of treatment: _____
_____

Unless you specifically direct otherwise in this request, records released may include information about psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection. I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature: _____ Date: _____
☐Patient ☐Authorized Representative (relationship: _____)
This authorization will expire in one year from date signed.

For Internal Use Only:
Photo ID checked ☐
Patient ID: _____