AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name____

Date of Birth: ____

Daytime Telephone Number: ____________________________________

I HEREBY AUTHORIZE:
Seaside Orthopaedic Clinic, Inc
1733 Seaside Road SW, Suite C
Ocean Isle Beach, NC 28469
910-575-9099 Telephone
910-575-9103 Fax

To Release Information To:

____
Name of Person or Organization

_____________________________________ _____________________
Street Address Phone Number

_____________________________________ _____________________
City, State, Zip Code Fax Number

This Release Includes: (Please Check Box for Requested Records)

☐ All Records ☐ Date of Service _______________

☐ Lab ☐ X-Ray Reports

☐ Other: ____

This authorization shall be valid until written notice is received. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only. I further understand that I have a right to receive a copy of this authorization upon request.

____ Date: _______________
Patient's Signature OR
Parent, Guardian or Authorized Representative