HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To request a copy of your notes, return this request/release form before December 1, 2023, by mail, fax or email to:

Interventional Orthopedics of Raleigh
7101 Creedmoor Road – Suite 109, Raleigh, NC 27613
Phone: 919-324-1704 Fax: 919-516-0070 Email: records@ioraleigh.com

There is no charge to send records by email or fax. A paper copy may be picked up from the office at no charge or mailed to you for a shipping fee of $5.

Patient Name *(printed)* : ____________________________________ **Date of Birth**: __________________

I authorize Interventional Orthopedics of Raleigh to send or disclose all my medical chart notes and imaging reports:

☐ - By email attachment to this email address *(no charge)*: _________________________________

☐ - By fax to this fax number *(no charge)*: ____

☐ - Printed version picked up at the offices of IOR before 12/15/23 *(no charge – we will call when ready).*

☐ - Printed version mailed to the following recipient *($5 shipping fee – enclose cash/check/call for cc).*

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Unless otherwise revoked, this authorization will expire automatically in ninety (90) days from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I understand that due to the nature of electronic delivery, documents delivered via email or fax may result in delivery or disclosure to unintended third parties.

I agree that a copy of this authorization is as valid as the original.

Signature of Patient: __________________________________ **Date**: _______________________