



Release of Medical Records

3320 Wake Forest Road
Suite 120
Raleigh, NC 27609

919.876.6755
Fax 919.876.6756
www.impactorthopaedics.com

Medical Record Number _____

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Mobile Phone: _____ Business Phone: _____

Email Address _____

Clinic (Location Releasing Information)

Clinic Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Recipient: Impact Orthopaedics, 3320 Wake Forest Road, Suite. 120, Raleigh, NC 27609

Dates of Service(s) Requested for Release: All dates Date Range: _____ through _____

Information to Be Disclosed: *

- Office Visits
- Consultation Reports
- Radiology Reports / Images (X-Ray, CT, MRI, Ultrasound, etc.)
- Physical Therapy Reports
- Hospital Records, including Operative Reports
- All of the Above
- Pathology Reports
- Laboratory Reports
- Other _____
- Worker's Compensation Reports

Reason for Release:

- Legal
- Selected New Physician
- Insurance Changed to _____
- Out-of-Town Move
- Insurance Claim Report
- Consult / Second Opinion
- Referred by Dr. _____

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature. I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the disclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient.

Patient / Parent / Guardian Signature: _____ Date Signed: _____

Relationship to Patient (if Parent / Guardian): _____ Reason Patient Unable to Sign: _____

To Be Completed by Clinic Releasing Information

Date Records Copied: _____ Copied by: _____

Medical Copies Were: Mailed Picked Up Faxed to _____