CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize Azalea Orthopedic & Sports Medicine Clinic, P.A. to release the following information from the health information records of:

   ____

   Patient Name

   ____

   Address City State Zip

   Covering the periods of care from: _______________________ to ________________________

   SSN: ______________________________ Date of Birth: _____________________

2. Information to be release:

   ______ Copy of complete health records

   ______ Excluding information related to HIV testing and / or results

   ______ History and Physical

   ______ Other: ____

3. Information to be release to: ____

   Address: ____

   Phone #: ____

   Fax #: ____

4. Purpose of Disclosure (circle): _____ Personal _____ Continued Care

   _____ Attorney _____ Insurance

   _____ Other: ____

5. I understand this consent can be REVOKED at any time except to extent that disclosure made in good faith has already occurred in reliance on this consent.

6. Specification of the date, event or condition upon which this consent expires <u>180 DAYS BY LAW, UNLESS OTHERWISE STATED.</u>

7. The facility, its employees, officers and attending physicians are released from legal responsibility and liability for the release of the above information to the extent indicated and authorized herein.

   Signed: ____

   Patient Date

Updated: 10.01.2018