CONSENT FOR RELEASE OF INFORMATION

This release must be completed in full for your request to be processed. Failure to complete the release will result in it being returned until properly filled out.

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: 11.07.2019