



Authorization to release PHI (Personal Health Information)

_____ I hereby authorize and request you send my medical records to SM&OC at:

SM&OC

201 E. Wendover, Greensboro, NC 27401

_____ I hereby authorize SM&OC to release my medical records to:

_____ I hereby authorize SM&OC to release my x-rays only to:

PLEASE PRINT LEGIBLY

Office Name: _____

Address: _____

Phone: _____ Fax: _____

Patient's Name: _____

Release PHI for the following dates: _____ to: _____

Authorization Expires: _____

Signature: _____ Date: _____

Type of information that may be released:

(Financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to SM&OC, a Division of Southeastern Orthopaedic Specialists, P.A. There is a potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI.