CARROLLTON ORTHOPAEDIC CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*The undersigned authorizes **Carrollton Orthopaedic Clinic** to release my health information as noted below.*

150 Clinic Avenue, Ste. 101 • Carrollton, GA 30117

Phone 770-834-0873

*Patient Information *Please Print**

Patient Full Name: ____________________________ **Date of Birth:** _____________ **Other Names?** _______________

Patient Address: ______________________________________ **Phone #:** __________________ **SS#** (last 4 digits)__________

City: ____________________ **State:** ______ **Zip:** ___________ **Email:** _______________________________________

Doctor completing form

Doctor: ____

Where do you want the form to be sent after completion?

Email address: ____

Your record/form(s) will be provided through our Secure Share Portal.

Name: ____ **Attention:** ____________________________________

Address: ____ **Phone:** ___________________________________

City: _______________________ **State:** ________ **Zip:** __________ **Fax #:** ________________________________

Purpose of Request: ____Personal ____Treatment ____Legal ____Insurance ____Transfer ____Other: _______________

Information to be Released

Please complete the attached form.

___I authorize the release of supporting medical records to supplement my leave claim.

___I am requesting leave starting: _____________________
(1st day of Leave)

___I am requesting intermittent leave.

Reason: _____________________________

Frequency: _______times per __ week __ month

Forms Completion:

A fee of not more than $40.00 ***per form*** is due prior to completion of the form(s). You will be contacted by Providerflow with payment options.

_____ Initials

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* ___________*(Please Initial)*

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ________________________. If I do not specify expiration, this authorization will expire in 1 year. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:____ **Date:** __________________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

****

__________________________________ ***Staff Signature / Date***

CREDIT CARD AUTHORIZATION FORM

CARDHOLDER INFORMATION:

Name:____

Street Address:_______________________________________

City:____________________ **State:**_________ **Postal Code:**_________________

Country:__________________________ **Email:**_____________________________

Telephone: (____)___-________

I hereby affirm that I am the owner of the below referenced credit card and that **my name** is listed on the front of the credit card.

I hereby authorize Providerflow to charge my credit card (listed below) in the amount of $___________.

CREDIT CARD INFORMATION:

Credit Card Type: □ MasterCard □ Visa □ American Express

Credit Card Number:____

Expiration Date:__________ **Security Code:**______

Cardholder Signature:____