

TOWN CENTER ORTHO ASSOC (TCOA) 1860 TOWN CENTER DRIVE #300
RESTON, VA 20190 Ph 703-435-6604 Fax 703-787-6575

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number (optional)

(City, state, zip code)

Phone (Home)

(Parent/Guardian if Patient<18 yrs)

At the request of the individual, I _____, do hereby authorize TCOA to release:

Patient Name _____

SERVICE DATES OF _____

OPERATIVE NOTES RADIOLOGY REPORTS ENTIRE CHART PHY THERAPY
OFFICE NOTES LAB/PATH REPORTS SPECIFIC INJURY

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**INFORMATION
RELEASED TO:**

Name of Company/Agency/Facility/Person

Street address

City, state, zip

____ e-delivery available to patient's personal email, must complete additional form available from TCOA

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST ____ INSURANCE ____ WORKERS COMP ____ LEAVING PRACTICE
____ LEGAL INVESTIGATION ____ DISABILITY DETERMINATION ____ PERSONAL ____ RELOCATION/MOVING
OTHER (SPECIFY) _____

Please provide preferred telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: HEALTHPORT WILL PROVIDE ONE COPY OF RECORDS FOR PERSONAL USE, OR CONTINUING CARE AT NO CHARGE. RECORDS WILL BE SENT BY STANDARD MAIL. HEALTHPORT DOES NOT FAX. IF APPLICABLE, VA STATE RATES APPLY. PGS 1-50, \$0.50 EACH, PGS 51+ \$0.25 EACH, PLUS POSTAGE.

Signature of individual or guardian or
Personal Representative of patient's estate Power of Attorney Must Be Attached

Date

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-Ray _____ OTHER _____
HP _____ PATH _____
ROI SPECIALIST _____
DATE _____