Town Center
ORTHOPAEDICS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ Print patient's full name

_____ Date of Birth (Mo/Day/Year)

_____ Street address

_____ Social security number (optional)

_____ City, State, Zip code

_____ Phone (Home)

_____ Parent/Guidarian if Patient is <18

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

_____
Address

_____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 (please specify): _____

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

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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: CIOX HEALTH WILL PROVIDE ONE COPY OF RECORDS FOR PERSONAL USE, OR CONTINUING CARE AT NO CHARGE. RECORDS WILL BE SENT BY STANDARD MAIL. CIOX 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 CIOX HEALTH

ENTIRE_____ LAB _____ EKG_____
DS_____ EKG _____ IMMUNE_____
OP_____ X-RAY _____ OTHER_____
HP_____ PATH _____ _____

_____

ROI Specialist

_____

Date