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_____ ROI SPECIALIST
OP_____ X-Ray_____ OTHER_____ _____
HP_____ PATH_____ _____ DATE

Revised 03.2012