TUCKAHOE ORTHOPAEDIC ASSOCIATES

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's name: _____ Date of birth: _____ SSN: _____

Phone #: (Home) _____ (Work) _____

I request and authorize _____ to release health care information and/or X-rays or MRI of the
(Name of Physician or Medical Practice)

patient named above to: Name: _____
(Name of individual or entity to receive the information)

Address: _____ City, State: _____ Zip code: _____

I would like my records: (please indicate one)

☐ Faxed; please provide FAX number: _____
☐ on a CD
☐ copied on paper

This authorization form applies to the following information (be specific). Describe the information to be used or disclosed, using meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc. In addition, if you are requesting copies of X-rays or MRI, please indicate exactly which X-rays or MRI are to be released (example: knee, shoulder, etc. – again, be specific). Please note that there may be a copying fee for medical records, X-rays and MRI.

_____

_____

_____

This protected health information is being used or disclosed for the following purposes: List specific purposes here. Please write "at the request of the individual" when the disclosure is requested by the patient.

_____

_____

THIS AUTHORIZATION IS EFFECTIVE THROUGH **(check one)** ☐ ____/____/____ or ☐ No Expiration unless revoked or terminated by the patient or patient's personal representative.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Tuckahoe Orthopaedic Associates has relied on my authorization. **I understand that to revoke this authorization, written notification should be sent to:** Denise Nichols, Privacy Officer, Tuckahoe Orthopaedic Associates, P. O. Box 71690, Richmond, VA 23255 – Phone (804) 285-2300, ext. 1646.

I understand that once this information is released by Tuckahoe Orthopaedic Associates, the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

I understand that Tuckahoe Orthopaedic Associates will not condition my treatment on whether I provide authorization for the requested use or disclosure.

If applicable, signing this authorization may result in permission for my physician to receive direct or indirect payment to the Tuckahoe Orthopaedic Associates from a third party based on the use or disclosure of my medical information.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

This completed Authorization for Release of Medical Information and any inquiries should be directed to:

Tuckahoe Orthopaedic Associates
Medical Records Dept.
P. O. Box 71690
Richmond, VA 23255

Phone: (804) 285-2300, ext. 1105
Fax: (804) 527-1824

Form Revised 11/28/2017