

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 _____
(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**