# TUCKAHOE ORTHOPAEDIC ASSOCIATES

## PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's name: _____ Date of birth: _____

Phone #: _____ Email: _____

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)**

**PURPOSE:** ☐ Patient ☐ Legal ☐ Insurance ☐ Continuing Care ☐ Other _____

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**INFORMATION TO BE RELEASED [required]**

Service Date Range : _____ Body Part:_____

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☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy ☐ Radiology Images (flat fee)

☐ Other (specify):_____

**DELIVERY METHOD**: I would like my records via (please indicate one)

☐ Paper (US Mail) ☐ Electronic format: CD/DVD ☐ Radiology Film/CD ☐ Patient Portal

☐ **eDelivery by Ciox (for patient's only) – email address:** _____

Address: _____City, State: _____Zip code: _____

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**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (required)**

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

I understand and acknowledge that these health records may include physical and mental illness, alcohol/drug abuse, genetics and/or HIV/AIDS test results or diagnosis.

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**

Form Revised 11/10/2021