

TUCKAHOE ORTHOPAEDIC ASSOCIATES, LTD.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

**** Provide the patient with a copy of the signed form. ****

Patient's name: _____

Date of birth: _____ SSN: _____

Phone #: (Home) _____ (Work) _____

I request and authorize _____ to release
(Name of Physician or Medical Practice)

health care information and/or X-rays or MRI of the patient named above to:

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

Address: _____

City, State: _____ Zip code: _____

This authorization form applies to the following information (be specific). 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.

[Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

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 EXPIRES ON _____
(Date)

OR WHEN THE FOLLOWING EVENT OCCURS:

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, Ltd. 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, Ltd., P. O. Box 71690, Richmond, VA 23255 – Phone (804) 288-2830, ext. 146.

I understand that once this information is released by Tuckahoe Orthopaedic Associates, Ltd., 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, Ltd. 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, Ltd. 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, Ltd.
Medical Records Dept.
P. O. Box 71690
Richmond, VA 23255**

Phone: (804) 285-2300, ext. 105

Fax: (804) 527-1824