

Commonwealth Orthopaedics

Getting back to **your** life.

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number

(City, state, zip code)

Phone (Home)

(Parent/Guardian if Patient < 18 yrs)

Chart #

At the request of the individual, I _____, do hereby authorize Commonwealth Orthopaedics to release:
Patient Name _____

SERVICE DATES OF _____

OPERATIVE NOTES _____ RADIOLOGY REPORTS _____ ENTIRE CHART _____ PHYSICAL THERAPY

PROGRESS 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

PURPOSE OF DISCLOSURE:

REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ LEAVING PRACTICE

LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL _____ RELOCATION/MOVING
OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize the 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 by Virginia statute, the practice has up to 15 days to prepare and release records. I understand that I may cancel this request with written notification but that it will not affect 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: Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia rates are \$0.50 per pg, pgs 1-50, \$0.25 per pg, pgs +51, plus postage and handling. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS. ALLOW 7-10 DAYS AFTER PAYMENT

Signature of individual or guardian or

Date

Personal Representative of patient's estate Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ROI _____

DATE _____

Revised 9/2011