TWIN CITIES ORTHOPEDICS

Internal Use Only | Account #_____
Pickup instructions _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. Patient:	Name	DOB
	Previous Name(s)	Primary Phone
	Address	Additional Phone
	City	State Zip

2. Release my records from:	Name	Dr. Name
	Address	
	City	State Zip

3. Release my records to:	Name		Dr. Name
	Address		Phone
	City		State Zip
Requests will not be processed if this section is not complete: ***Requests may take up to 2 weeks to be processed.***	☐ Office Notes ☐ Radiology/MRI Images on CD ☐ Lab reports	☐ Radiology/MRI reports ☐ Hospital Records ☐ Therapy (Physical and Occupational)	To release records for only specific dates or body parts, please complete this section: ☐ Body Part only _____ ☐ Date(s) of service _____

4. For Verbal Disclosure, check here _____	"Verbal Disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section.

5. Reason For Request:	☐ Personal Use ☐ Disability	☐ Insurance ☐ Legal	☐ Worker's Compensation ☐ Continuing Care

6. Return completed form to:	Twin Cities Orthopedics Attn:ROI Dept. 5803 Neal Ave. N. Oak Park Heights, MN 55082 763-504-2729	Or **email to:** recordsrelease@TCOmn.com Or **fax to:** 952-456-7020 Or drop off at any TCO Location	Records will be mailed to the person(s) or facilities identified in section 3 unless other arrangements for delivery are made at time of form submission.

7. I understand that by signing below	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicated in sections 2 and 3 of this form. • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form. **Signature of Patient/Guardian _____ Date _____** **Print Name _____** **If form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.*