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 INFORMATION** | PATIENT NAME: | | |
| | DOB: / / | PREVIOUS NAME(S): | |
| **2. RELEASE MY RECORDS FROM** | FACILITY NAME: | | |
| | DR. NAME: | | |
| **3. SEND MY RECORDS TO** | NAME: | ATTN TO: | |
| | ADDRESS: | | |
| | CITY: | STATE: | ZIP: |
| | PHONE: | FAX (For Continuing Care ONLY): | |
| | EMAIL:<br>(Only if you want records sent via encrypted email) | | |
| **4. TYPES OF RECORDS** | BODY PART: | | |
| | DATE(S) OF SERVICE: | | |
| | ☐ Office Notes<br>☐ Radiology Reports<br>☐ Lab Reports | ☐ Hospital Reports<br>☐ Therapy (Occupational or Physical) | |
| **5. VERBAL DISCLOSURE** | For verbal disclosure, check here: _____ | | |
| | "Verbal disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section: | | |
| **6. REASON FOR REQUEST** | ☐ Personal Use<br>☐ Disability | ☐ Insurance<br>☐ Legal | ☐ Workers Compensation<br>☐ Continuing Care |
| | Do you need imaging on a CD? ☐ Yes ☐ No | | |
| **7. RETURN COMPLETED FORMS TO:** | **MAIL TO:**<br>Treating Clinic Location<br>(see details at **TCOmn.com/Locations**) | **EMAIL TO:** recordsrelease@TCOmn.com<br>**FAX TO:** 414- 255 - 2776<br>**DROP OFF:** Treating Clinic Location | |
| | * Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing. | | |

**8. I UNDERSTAND THAT BY SIGNING THE 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 indicted above
- 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: _____ DATE: _____

PRINT NAME: _____

*If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.

***Electronic or Typed Signatures cannot be accepted***