TWIN CITIES ORTHOPEDICS

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: (Only if you want records sent via encrypted email)

4. TYPES OF RECORDS	BODY PART:
	DATE(S) OF SERVICE:
	☐ Office Notes ☐ Hospital Reports ☐ Radiology Reports ☐ Therapy (Occupational or Physical) ☐ Lab Reports

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 ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care
	Do you need imaging studies? ☐ Yes ☐ No (All images will be sent via email)

7. RETURN COMPLETED FORMS TO:	**MAIL TO:** Treating Clinic Location (see details at **TCOmn.com/Locations**)	**EMAIL TO:** recordsrelease@TCOmn.com **FAX TO:** 414- 255 - 2776 **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.