

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

<b>1. PATIENT INFORMATION</b>	PATIENT NAME:		
	DOB:     /     /	PREVIOUS NAME(S):	
<b>2. RELEASE MY RECORDS FROM</b>	FACILITY NAME:		
	DR. NAME:		
<b>3. SEND MY RECORDS TO</b>	NAME:		ATTN TO:
	ADDRESS:		
	CITY:	STATE:	ZIP:
	PHONE:		FAX: (For Continuing Care ONLY)
	EMAIL: (Only if you want records sent via encrypted email)		
<b>4. TYPES OF RECORDS</b>	BODY PART:		
	DATE(S) OF SERVICE:		
	<input type="checkbox"/> Office Notes <input type="checkbox"/> Hospital Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Therapy (Occupational or Physical) <input type="checkbox"/> Lab Reports		
<b>5. VERBAL DISCLOSURE</b>	For verbal disclosure, check here: _____		
	"Verbal disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section:		
<b>6. REASON FOR REQUEST</b>	<input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> Continuing Care		
	Do you need imaging on a CD? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>7. RETURN COMPLETED FORMS TO:</b>	<b>MAIL TO:</b> Treating Clinic Location (see details at <a href="http://TCOmn.com/Locations">TCOmn.com/Locations</a> )		<b>EMAIL TO:</b> recordsrelease@TCOmn.com <b>FAX TO:</b> 414- 255 - 2776 <b>DROP OFF:</b> Treating Clinic Location
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
<b>8. I UNDERSTAND THAT BY SIGNING THE BELOW:</b>	<ul style="list-style-type: none"> <li>I may revoke this authorization at any time by notifying the facility identified above in writing.</li> <li>By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed.</li> <li>There may be a fee for release of this information and I may be responsible for that fee.</li> <li>I am authorizing the release of my personal protected health information to and from the entities I've indicated above</li> <li>Treatment will not be denied to me if I do not sign this form.</li> <li>This authorization will expire one year from the date I sign on this form.</li> </ul>		
	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.			